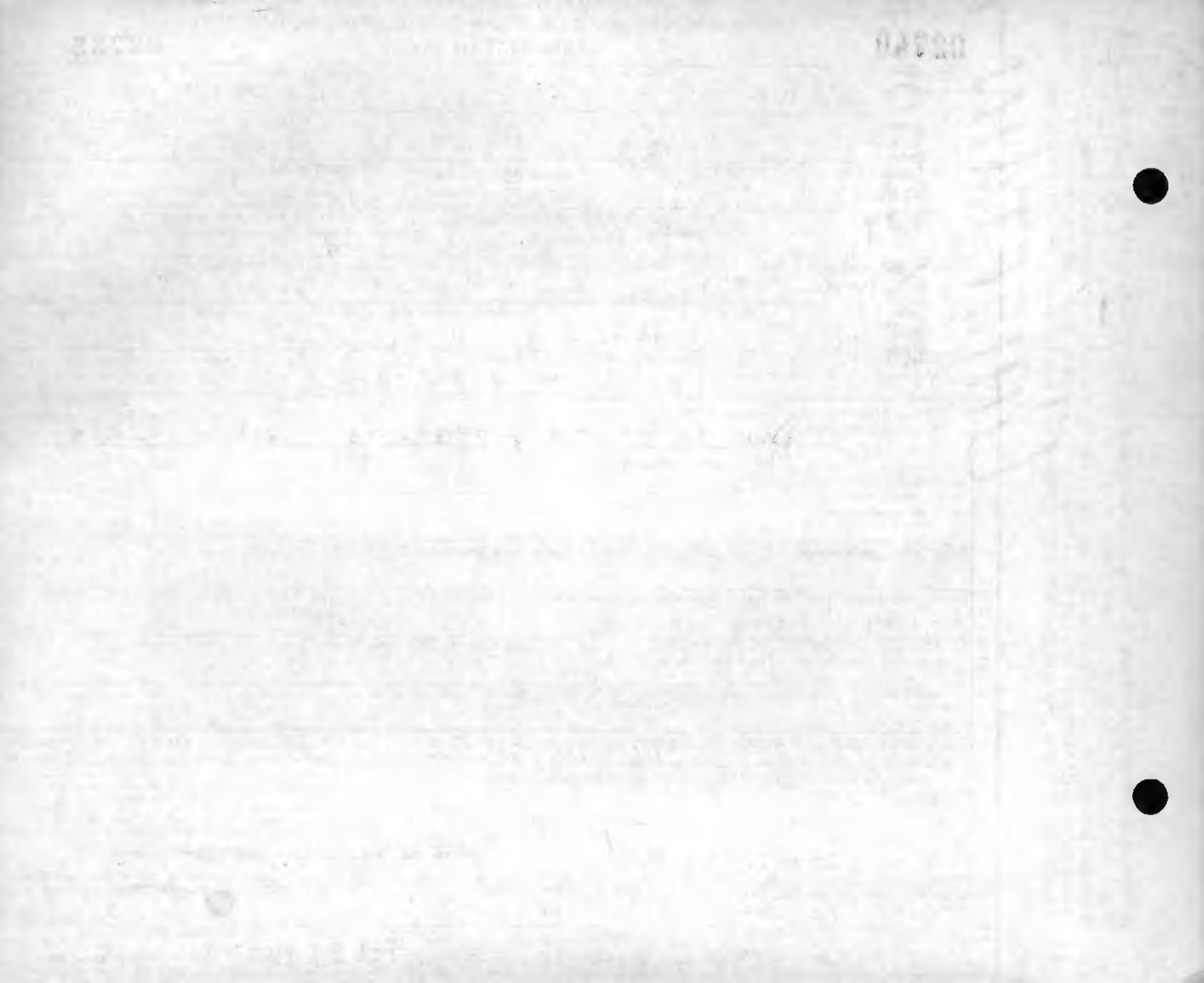


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02740				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02735			
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR			
First Middle Last Milton E. Abrams				Feb Month 17 Day 69 Year				725 P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M		Negro		7-09-18		50 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md		USA				Prince George				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince Georges		farmer		tobacco					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md		Pr Geo		Upper Marlboro				Rt 2085 Rt 301			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First Middle Last Daniel Abrams		First Middle Last Hattie Smith									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		Yes but unk		Ethel Abrams		Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Tongue</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2-3-69		Biopsy Tongue		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>2 Feb</u> , 1969, to <u>17 Feb</u> , 1969, that (I) (we) last saw the deceased alive on <u>2-17</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
James C. King, M.D.		2-17-69		James C. King, M.D.		6001 Landover Rd., Cheverly, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
		2-20-69		Mount Cemetery		Upper Marlboro, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Rollins F.H.		4339 Hunt Pl. N.E. D.C.		DATE FEB 21 1969		O'Connell, Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-8. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
Earl				Ahmay		Jr.		<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 2-20-69 198:50am		50am	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	7-20-1922	46 YRS	MONTHS DAYS		HOURS MIN.		2 Month 20 Day 69 Year 19 8:50am		50am	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
Washington D C		U S A		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's County				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince George Hospital		Railroad		Washington Terminal					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) -STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Prince George's		Lanham		YES <input type="checkbox"/> NO <input type="checkbox"/>		5646 Whitfield Chapel Road			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Earl Ahmay sr								Evelyn Knott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
yes		577 20 1362		Ruth N Ahmay		Lanham, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> 571.9 DUE TO, OR AS A CONSEQUENCE OF <u>Cirrhosis of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John Kehoe MD		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		2-21-69	
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Feb 24, 1969		Mt Olivet Cemetery		Washington D C					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons				Hyattsville, Md.				FEB 24 1969		[Signature]	

No. 1-1	Date	1913
Name of person or firm	Address	City
Occupation	County	State
Description of property	Acres	Value
Crops	Livestock	Other
Remarks		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, poppets. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18c Film 40 3-21-69 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02737											
02742 1. DECEASED-NAME (Type or print) First Middle Last Forrest Allen						2a. DATE OF DEATH Month Day Year Feb. 27, 1969				2b. HOUR P. 7:55 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11/11/09		6. AGE (In years lost birthday) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Washington D C		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Maintenance man		12b. KIND OF BUSINESS OR INDUSTRY U of Md					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5401 56th Place, Apt. #102			
14. FATHER'S NAME First Middle Last Theodore Allen				15. MOTHER'S MAIDEN NAME First Middle Last Nata Ellis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 579 05 0196		17. INFORMANT Agnes T Allen		Address Riverdale, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive Right Lobar Pneumonia</u> 1619 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Metastatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of larynx</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-29</u> , 19 <u>68</u> , to <u>2-27</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 2/28/69					
22d. PHYSICIAN'S NAME (Type) JOHANNES SAHAKYAN		22e. ADDRESS 6001 Landover Rd., Cheverly, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 3, 1969		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven cemetery		23d. LOCATION (City or Town) (County) (State) Wheaton Montgomery Md					
24. FUNERAL DIRECTOR F. Gasch's Sons		Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 4 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

Date: _____

Page: _____

Subject: _____

To: _____

From: _____

Re: _____

Reference: _____

Enclosure: _____

Distribution: _____

Comments: _____

Signature: _____

Title: _____

Organization: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Fax: _____

E-mail: _____

Web: _____

Notes: _____

Attachments: _____

Comments: _____

Signature: _____

Title: _____

Organization: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Fax: _____

E-mail: _____

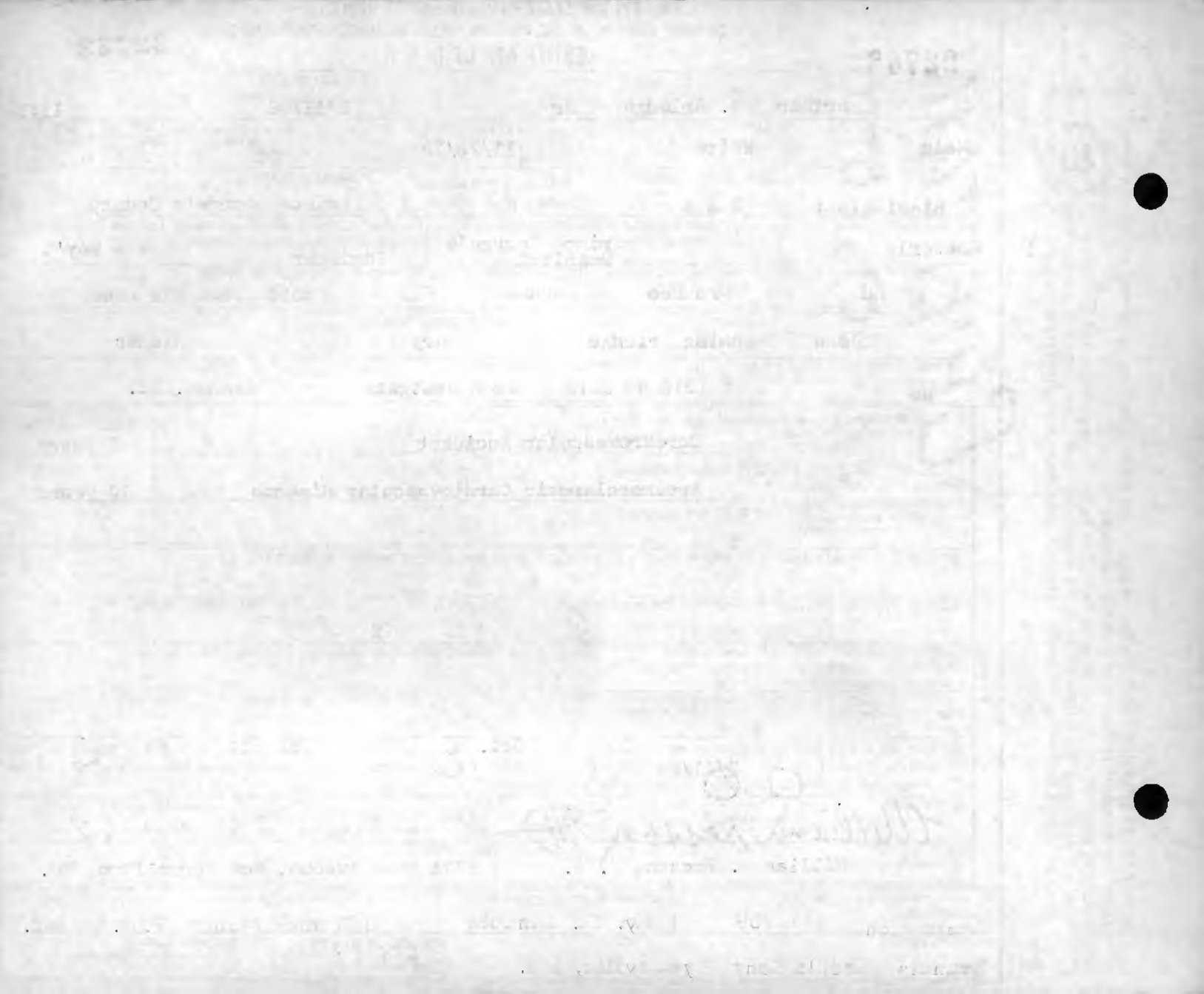
Web: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Arthur E. Arledge Sr			2a. DATE OF DEATH Month 2 Day 11 Year 69			2b. HOUR 11:10	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11/28/78		6. AGE (In years lost birthday) 90 YRS.	
7a. BIRTHPLACE (State or foreign country) Mississippi		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer		12b. KIND OF BUSINESS OR INDUSTRY U S Gov't	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. CITY OR TOWN Pro Geo Lanham		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5615 Westgate Lane	
14. FATHER'S NAME First John Middle Manning Last Arledge			15. MOTHER'S MAIDEN NAME First Mary Middle Richer Last Richer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 215 46 2518		17. INFORMANT Mae A Westgate		Address Lanham, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct. 4 , 19 66 , to Feb 11 , 19 69 , that (I) (we) lost saw the deceased alive on 2/11/69 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE William D. Rosson				22c. DATE SIGNED 2/11/69			
22d. PHYSICIAN'S NAME (Type) William D. Rosson, M. D.				22e. ADDRESS 5701 85th Avenue, New Carrollton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 2/12/69		23c. NAME OF CEMETERY OR CREMATORY Exx Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE FEB 14 1969		25b. REGISTRAR'S SIGNATURE William D. Rosson	



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last ANNA B BAICAR			2a. DATE OF DEATH Month Day Year 2 2 69			2b. HOUR 3 40 M			
3. SEX F		4. RACE White		5. DATE OF BIRTH 6-22-1879		6. AGE (In years last birthday) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. George Md.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pineview Garden		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Pr. George		13c. CITY OR TOWN Indian Head		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 14 Green Meadows	
14. FATHER'S NAME First Middle Last Bahar			15. MOTHER'S MAIDEN NAME First Middle Last Anna Bachar			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 579-50-9154			17. INFORMANT MARTIN E. BAICAR			Address INDIAN HEAD MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY HEART ARTERIOSCLEROSIS</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>DIABETES MELITUS</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Alfred R. Lapin MD				22c. DATE SIGNED 2-27-69		22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-4-69		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL Cemetery		23d. LOCATION (City or Town) (County) (State) SUITLAND P.G. Md.		23e. REC'D BY REGISTRAR FEB 7 1969	
24. FUNERAL DIRECTOR Alfred R. Lapin				24b. ADDRESS WALDORF, MD		25b. REGISTRAR'S SIGNATURE			

RTSC

1980

1980

1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02745									
CERTIFICATE OF DEATH									
02740									
1. DECEASED NAME (Type or print) First Middle Last <i>Manie Barnes</i>					2a. DATE OF DEATH Month Day Year <i>2 11 69</i>				
3 SEX <i>Female</i>		4. RACE <i>negro</i>		5. DATE OF BIRTH <i>2/10/1895</i>		6. AGE (In years last birthday) <i>74</i> YRS.		2b. HOUR <i>5:55 A.M.</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George</i> Md.			
10. CITY OR TOWN OF DEATH <i>CLINTON</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Pine View Gardens</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Domestic</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>D.C.</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY WARD? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5002 Hst S.E.</i>	
14. FATHER'S NAME First Middle Last <i>JEAN Smith</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Smith</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Henry Barnes-</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1: DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <i>Cardiocardular Collapse</i>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <i>Uremia</i>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Decubitus due to uremia</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <i>1/31</i> , 19 <i>69</i> , to <i>2/11</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2-11-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Alfred R. Lapin, M.D.</i>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2-11-69</i>		
22d. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPIN, M.D.</i>					22e. ADDRESS <i>CLINTON, MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-15-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Memorial</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>			
24. FUNERAL DIRECTOR <i>John T. R... Co.</i>					ADDRESS <i>3005 12th St. N.E.</i>		25a. REC'D BY REGISTRAR <i>FEB 17 1969</i>		25b. REGISTRAR'S SIGNATURE



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02746

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02741

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 2-21-69 1912:05am			2b. HOUR
Ernest Eugene Beall Sr									
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	F UNDER 1 YEAR MONTHS DAYS HOURS MIN		F UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 2 21 69 191:05am M	
Male	White	5-11-1919	49 YRS						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md			
Md		U S A							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital			Maintenance		Construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution a Residence before admission) - STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Prince George's		Bowie		YES <input type="checkbox"/> NO <input type="checkbox"/>		8704 Brady Road
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Howard E Beall						Estelle Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS
Yes			214 16 8259			Linda Ann Utz			N. Laurel, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inhalation of smoke</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and burns of 35% of body surface</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:00am 2-21- 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Burned in house fire				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No same as #13		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			John Kehoe MD Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 2-21-69	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb 24, 1969		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
F Gasch's Sons Hyattsville, Md.						FEB 24 1969			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> 02747 CERTIFICATE OF DEATH 02742 </div>										
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
<div style="display: flex; justify-content: space-between;"> First Middle Last </div> Frances T. Beatly					<div style="display: flex; justify-content: space-between;"> Month Day Year </div> Feb. 9th. 1969			<div style="display: flex; justify-content: space-between;"> Hours Min </div> 5:45 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		12 Jan. 1881		88 YRS.		<div style="display: flex; justify-content: space-between;"> MONTHS DAYS HOURS MIN </div>		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Mississippi		U.S.A.				Prince George's Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Hyattsville			Hyattsville Nursing Home			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Pr. Geo.		Hyattsville				3326 Lancer Drive	
14. FATHER'S NAME			15. MOTHER'S M A D E N NAME							
<div style="display: flex; justify-content: space-between;"> First Middle Last </div> Thomas Templeton			<div style="display: flex; justify-content: space-between;"> First Middle Last </div> Nancy Mathews							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give War or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No			261-46-0757		Isabel Woodside		(Same as # 13)			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular disease										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B)						
		<div style="display: flex; justify-content: space-between;"> HOUR A.M. Month Day Year </div> P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION						
<div style="display: flex; justify-content: space-between;"> White Not white </div> <input type="checkbox"/> at work <input type="checkbox"/> at work				<div style="display: flex; justify-content: space-between;"> Street or R.F.D. No. City or Town County State </div>						
22a. I certify that (I) (this hospital) attended the deceased from June , 1968, to 9 Feb. , 1969, that (I) (we) last saw the deceased alive on 8 Feb. , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death										
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Dr. Robert Deitz									2-9-69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Dr. Robert Deitz					Pr. Geo. Piazza, Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Feb 11, 1969		Oak Lawn Cemetery		Charlotte Mecklenburg N. C.				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons					Hyattsville, Md.		FEB 13 1969		Isabel Woodside	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH	
Nicholas			Peter		Bellavin				24 Month 5 Day 69 Year 53-0 M	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS	
Male		White		11-20-83			87 85 YRS			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Russia			U.S.A.					Prince George's County Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Cheverly			E.C.F. - P.G.G.H.			Orthodox Priest				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) - STATE			13b COUNTY		13c CITY OR TOWN		3a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Prince George's		Suitland				4706 Homer Avenue	
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME	
Peter			Bellavin		Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			3859 Address Barnabas Rd. Marlow Hgts.	
Unknown			Unknown			Ignatius N. Bellavin, son				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u>										Symptoms
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>arteriosclerosis & arteriovenous fistulae</u>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, EARM STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		Street or R.F.D. No		City or Town		County
22a I certify that (I) did not attended the deceased from <u>12-24</u> , 19 <u>69</u> , to <u>2-5</u> , 19 <u>69</u> , that (I) was last saw the deceased alive on <u>2/5/69</u> , 19 <u>69</u> , and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) did not (d) not view the body after death.										
22b SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED
<u>Leon Levitsky, M.D.</u>										2/6/69
22d PHYSICIAN'S NAME (Type)						22e ADDRESS				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		2/8/69		Washington National		Washington, D. C.				
24. FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Robert F. Wilhelm Funeral Home						FEB 11 1969		<u>Charles Judge</u>		
4308 Suitland Rd., S. E. Suitland, Md. 20023										

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FOR STATE HEALTH DEPT.

MARYLAND DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR			
Curtis L. Birley sr						Month Day Year			2:50 P M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 24 HRS MONTHS	8. UNDER 24 HRS DAYS	9. UNDER 24 HRS HOURS	10. UNDER 24 HRS MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR	
M	W	13 May 1935	33 YRS					Month Day Year			2:50 P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			10. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			11. KIND OF BUSINESS OR INDUSTRY
Pa		U S A				Prince George			Mechanic			Don's American
12. CITY OR TOWN OF DEATH			13. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			14. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			15. KIND OF BUSINESS OR INDUSTRY			
Riverdale			Leland Hosp									
16a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE			16b. COUNTY			17. CITY OR TOWN			18. INSIDE CITY LIMITS?			19. STREET AND NUMBER
Md			Prince George Glendale						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Box 145 Annapolis Rd.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO			17. INFORMANT			18. ADDRESS
Charles C Birley			Olive Mae Yost			216 30 2567			June L Birley			Glenn Dale, Md.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			18. ADDRESS			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
no			216 30 2567			June L Birley			Glenn Dale, Md.			10 hrs.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Heart failure												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
(b) Arteriosclerotic heart disease over 8 mos												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			10 hrs.			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
			19 P.M.						10 hrs.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
						City or Town County State			10 hrs.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			John Kehoe M.D. Riverdale			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			John Kehoe			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			3-1-69			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			March 3, 1969			Ft Lincoln Cemetery			Colmar Manor Ar Geo Md.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			26. ADDRESS			
F. Gasch's Sons			MAR 4 1969			Hyattsville, Md.						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-8. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Rose Bloom						Feb 19 1969			1 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		2-23-06		62 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Balt. Md.		U. S. A.				P. G. C.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Greenbelt - Md.		Greenbelt Conv Center		XXXX HOUSEWIFE		AT HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		WEST		HYATTSVILLE				3111 ROSE MARY LANE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Maurice Greenbaum			Molly Sherman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT			
NO				213-03-2557		MR. HOWARD M. FLOOM, 3111 ROSE MARY LANE, WEST HYATTSVILLE, MD. 2078			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma									
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of (L) Breast									Jan 1965
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
9a. DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (the hospital) attended the deceased from 17 Nov 1968, to 17 Feb 1969, that (I) (we) last saw the deceased alive on 17 Feb 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
Arthur Kaufman		19 Feb 69			ARTHUR KAUFMAN, M.D.				
22e. ADDRESS		22f. ADDRESS							
GREENBELT PROF BLDG, GREENBELT									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2-20-69		ANSHE EMUNAH (AITZ CHAIM)		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG-STRAR		25b. REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				DATE		FEB 24 1969			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02745							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First			Middle			Last			2a. DATE KNOWN OF DEATH ESTIMATED Month Day Year		2b. HOUR p M			
Billie			Carlton			Boyd						2 15 1969		8:55 p M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 24 HRS MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR p M					
M		B		11-29-1944		24 YRS				2 15 1969		9:45 p M					
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH					
Georgia				USA								Prince George Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USLA. OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly				Prince George Hosp				Mechanic				Automobile					
13a. USLA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY (If not)		13e. STREET AND NUMBER			
Md				Prince George Suitland								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4692 Homer Ave.,			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
Jack Boyd				Nina L. Poole													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT				ADDRESS					
yes <input checked="" type="checkbox"/>				1966-1968				577-58-7111				Nina L. Tharaldsen 4692 Homer Ave, Suitland, Md., 20023					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Laceration of brain												Minutes					
Trauma-auto accident																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUSE 8:49 P.M. 2 15 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver of car in collision									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Suitland Rd.				21f. LOCATION Street or R.F.D. No City or Town County State Suitland P.G. Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				John Kehoe, M.D., Riverdale				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED 2-16069					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				2/19/69				Oakhill Cemetery				Canton, Georgia					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Robert B. Wilhelm Funeral Home 4308 Suitland Rd., S. E. Suitland, Md., 20023				FEB 20 1969				O'Donoghue, Judge									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02747					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED NAME (Type or Print)			First		Middle		Last			2a DATE KNOWN OF DEATH		2b HOUR			
William Arthur Boyd										2-19-69		19 1:18am			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
Male		White		6-18-1924		44 YRS		MONTHS		DAYS		2		19 192:34am M	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Pennsylvania			USA						Prince George's			Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USJA. OCCUPATION (Kind of work done during most of work ing life even if retired)			12b KIND OF BUSINESS OR INDUSTRY						
Cheverly			Prince George Hospital			Insurance									
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
Maryland			Anne Arundel Co			Crofton			YES <input type="checkbox"/> NO <input type="checkbox"/>			1638 Dryden Lane			
14 FATHER'S NAME			First		Middle		Last			15. MOTHER'S MAIDEN NAME			First Middle Last		
Arthur Elder Boyd										Mary Marilla Ayres					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			20. YRS. incl WW 11			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS			
yes						216-12-8583			Mrs. Frances L. Boyd - Crofton, Md.			1638 Dryden			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain															
DUE TO, OR AS A CONSEQUENCE OF Fracture of skull															
(Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last)															
(b) Trauma - auto accident															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 18 or Part 21b)							
				1:15am 2-19- 19 69				Driver of car which went out of control and							
21d INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Church Road and Rt. 50., Prince George County, Maryland											
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED							
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				2-20-69							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street city town or county)							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)						
BURIAL				2/24/69		ARLINGTON NATIONAL CEM.			ARLINGTON, VIRGINIA						
24 FUNERAL DIRECTOR						ADDRESS			25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE				
FALLS CHURCH FUNERAL HOME, FALLS CHURCH, VA.									FEB 24 1969						



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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02753

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02743

1 DECEASED NAME (Type or Print)		First Daniel		Middle S		Last B radshaw		2a DATE KNOWN OF DEATH		Month <input checked="" type="checkbox"/> 2		Day 8		Year 1969		2b HOUR 2:20 P.M.			
3 SEX M		4 RACE W		5 DATE OF BIRTH 18 Oct 1920		6 AGE (In years last birthday) 48 YRS		7 IF UNDER 1 YEAR MONTHS DAYS		7 IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month 2 Day 8 Year 1969				2d HOUR 2:20 P.M.			
7a BIRTHPLACE (State or foreign country) Va				7b CITIZEN OF WHAT COUNTRY? U S A				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Prince George				Md			
10 CITY OR TOWN OF DEATH Andrews AFB				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcom Crow Hosp				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk				12b KIND OF BUSINESS OR INDUSTRY Safeway Store Inc				Md			
13a USUAL RESIDENCE (Where deceased lived, if at institution, residence before admission) STATE Md.				13b COUNTY Prince George				13c CITY OR TOWN Upper Marlboro				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e STREET AND NUMBER 10609 Kaine Place			
14 FATHER'S NAME First Middle Last John Bradshaw				15 MOTHER'S MAIDEN NAME First Middle Last Lulu Dameron															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b SOCIAL SECURITY NO. WW 11 197 12 1162				17 INFORMANT Mildred L Bradshaw				ADDRESS Upper Marlboro, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 412.3 IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min. 5 yrs.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b DATE SIGNED 2-9-69											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Feb 12, 1969				23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.							
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE FEB 13 1969				25b. REGISTRAR'S SIGNATURE Edmond J. Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR
Philip Harry Bransdorf						Feb 26 1969			5:05 P M
3 SEX	4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
Male	White		3-31-97			71 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York City		U.S.A.				Prince Georges Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince Georges General			Insurance Broker			
13a USUAL RESIDENCE (Where deceased administered)		13b COUNTY		13c CITY OR TOWN		13d INS OF CITY, STATE?		13e STREET AND NUMBER	
Md.		P. G.		Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		7203 Wells Blvd.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Reuben Bransdorf			Betty Miller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT		Address		
			577-07-2703		Geneva Bransdorf		same as above		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction									
41- DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (1) (this hospital) attended the deceased from 10 Feb., 1969, to 26 Feb., 1969, that (1) (we) last saw the deceased alive on 26 Feb., 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
22d PHYSICIAN'S NAME (Type)					22e ADDRESS				
Dr. R. Ditz					Hyattsville, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		2/28/69		Washington National Cem.		Prince Georges County			
24 FUNERAL DIRECTOR The S. A. Hines Company					25a. MAR 4 1969		25b. REGISTERED SIGNATURE		
2901 14th St. N.W. Washington, L.C.					DATE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02755

02750

1 DECEASED-NAME (Type or print) <i>Siue</i> First <i>C.</i> Middle <i>Brent</i> Last			2a. DATE OF DEATH <i>2</i> Month <i>27</i> Day <i>69</i> Year		2b. HOUR <i>12:55</i> M
3 SEX <i>Female</i>	4 RACE <i>NEGRO</i>	5. DATE OF BIRTH <i>10. 22. 78</i>		6. AGE (In years last birthday) <i>90</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George's</i> Md.	
10. CITY OR TOWN OF DEATH <i>Maryland</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Regent Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>DC</i>		13b. COUNTY <i>WASHINGTON</i>	13c. CITY OR TOWN <i>WASH</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>4660 Nichol Ave SW</i>
14 FATHER'S NAME First <i>Amos</i> Middle <i>Jane</i> Last			15 MOTHER'S MAIDEN NAME First <i>Margaret</i> Middle <i>Dean</i> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT <i>daughter</i> Address <i>4660 Nichol Ave.</i> <i>Mrs Margaret B Williams</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4120 Cerebral hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF <i>Cerebral arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Hypertensive cardiac disease</i> (b) <i>unknown</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>unknown</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>68</i> , to <i>2 27</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2. 26.</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Henry G Hadley</i>		DEGREE ATTENDING <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. DIRECTOR PHYS.		22c. DATE SIGNED <i>2. 27. 69</i>	
22d. PHYSICIAN'S NAME (Type) <i>HENRY G HADLEY</i>		22e. ADDRESS <i>4601 Nichol Ave SW</i>			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <i>3/3/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Memorial Park</i>	
23d. LOCATION (City or Town) <i>Maryland</i>		(County)		(State)	
24. FUNERAL DIRECTOR <i>John T. Stewart</i>		25a. REC'D BY REGISTRAR <i>MAR 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. Stewart</i>	
Stewart Funeral Home-4001 Benning Road, N.E.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

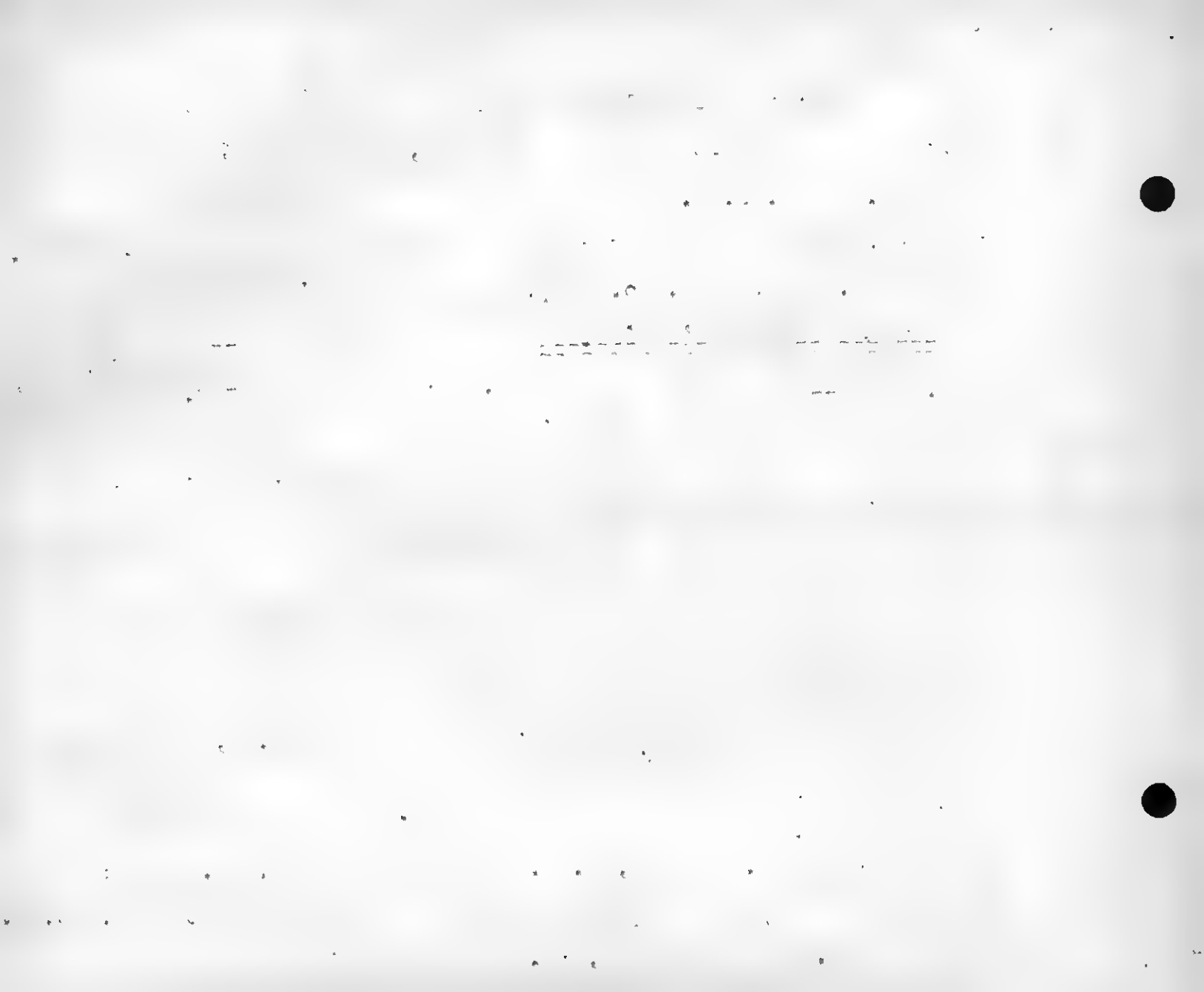
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1518
30M REV 11/58

02756

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Grover Cleveland Buck			2a. DATE OF DEATH Month Day Year Feb 13 1969		2b. HOUR Min 2:30
3. SEX Male	4. RACE White		5. DATE OF BIRTH April 1, 1893		6. AGE (In years lost birthday) 75 YRS
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges
10. CITY OR TOWN OF DEATH Upper Marlboro		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Box 132		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Foreman	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Upper Marlboro	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box 132
14. FATHER'S NAME First Middle Last DANIEL BUCK, SR.			15. MOTHER'S MAIDEN NAME First Middle Last REBECCA -- ROBISON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No.		16b. SOCIAL SECURITY NO --		17. INFORMANT Address Box 132 Upper Marlboro, Md. Mrs. Mamie Vernon Buck	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1651 Cerebralia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last Carcinoma tons demoid cyst of the maxillary sinus (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo Unk					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from June 1968 , to Feb. 13, 1969 , that (I) (we) last saw the deceased alive on Feb. 13, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert B. Sasscer				22c. DATE SIGNED 2/13/69	
22d. PHYSICIAN'S NAME (Type) Robert B. Sasscer, M. D.				22e. ADDRESS Upper Marlboro, Md. 20870:	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/16/69		23c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery	
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		23d. LOCATION (City or Town) (County) (State) Upper Marlboro Pr. Geo. Md.		25a. REC'D BY REGISTRAR FEB 17 1969	
				25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~pages 1 and 2~~ should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02757 Item 13 Film G409 2/24/69 kk											
02752											
1. DECEASED-NAME (Type or print) Magdalene Buckler						2a. DATE OF DEATH Month Feb Day 9 Year 1969			2b. HOUR 8-45 AM		
3 SEX F		4. RACE Cauc.		5. DATE OF BIRTH 8-10-89		6 AGE (In years last birthday) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md					
10. CITY OR TOWN OF DEATH Forestville, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rege-d Nrsng. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret Teacher			12b. KIND OF BUSINESS OR INDUSTRY		
13a USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Washington			13b COUNTY D.C.			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1605 Minn. Ave. S.E.	
14. FATHER'S NAME First Patrick Middle Burns Last Sophia			15. MOTHER'S MAIDEN NAME First Henardy Middle Henardy Last Henardy								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17 INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion (b) Coronary Atherosclerosis (c) Indef.											
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Atherosclerosis Confusion, Auricular Fibrillation, Exrthif.											
19a DATE OF OPERAT ON			19b. CONDITION FOR WHICH OPERAT ON WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/15/67 to 2/9/69 , that (I) was lost saw the deceased alive on 2/9/69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above yes (did) (did not) view the body after death.											
22b SIGNATURE Kelvin L. Minchin DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c DATE SIGNED 2/9/69					
22d. PHYSICIAN'S NAME (Type) KELVIN L. MINCHIN						22e ADDRESS 6400 MARLBORO PIKE SE WASH D.C.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Removal Feb. 13, 1969 Assumption						St Cloud, Minn					
24. FUNERAL DIRECTOR Washington Metropolitan Funeral Service, Falls Church, Va. 22041						25a REC'D BY REGISTRAR FEB 17 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
EARL		A		BUNGOR		2		28 1969	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR	
Male		Cau		4-13-1887		82 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
KANSAS		U.S.A				PRINCE GEORGES Md			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KND OF BUSINESS OR INDUSTRY			
HYATTSVILLE		Hyattsville Nursing Home							
13a USLA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
D.C.		16b COUNTY		Washington		YES		5309 1st N.W.	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
LAWRENCE		BUNGOR		MARY					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17. INFORMANT		Address			
No		577 40 8598A		Mrs Lucile F. Bungor		5309 1st N.W.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) MYOCARDIA INFARCTION								ACUTE	
DUE TO, OR AS A CONSEQUENCE OF									
CONDITIONS, if any, which gave rise to immediate cause (a) (b) ARTERIOSCLEROTIC HEART DISEASE								YEARS	
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
UREMIA									
19a DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1967 to 28 FEB, 1969, that (I) (we) last saw the deceased alive on 27 FEBRUARY 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED	
Morrill C. Quinnam Jr. M.D.				<input checked="" type="checkbox"/>				2-28-69	
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
MORRILL C. QUINNAM JR. M.D.		831 UNIVERSITY BLVD E. SILVER SPRING							
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		March 4, 1969		St. George Washington Cemetery		Adelphi		Prince Georges Md	
24. FUNERAL DIRECTOR		ADDRESS		25a REGD BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
John J. Quinnam Jr.		254 Carroll Rd		DATE MAR 4 1969		John J. Quinnam Jr.			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PR-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Wendell Lawrence Burke						ESTIMATED <input checked="" type="checkbox"/> 2 23 1969		5:00 PM	
3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS MONTHS	YEAR	8 UNDER 24 HRS HOURS	MIN	2c. DATE PRONOUNCED DEAD	2d. HOUR
M	W	1 Mar 1909	59					Month 2 Day 23 Year 19 68	6:28 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		U.S.A.		Prince George					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Co. Hosp.			Night Foreman		Chemical	
13a. USUAL RESIDENCE (Where deceased lived, if institut an admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Not Pa.			Delaware		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		734 Ashland Ave.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Not ascertainable			Mary Burke						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
No			159-07-2681		Sara M. Burke		734 Ashland Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min 2 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County
									State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)			John Kehoe, M.D., Riverdale			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2-23-69	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		27 Feb. 1969		Mem. Park George Washington		Whitemarsh, Mont. Co., Pa			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John E. Boulaia		Greensboro, Md.		FEE 28 1969		Charles Guise			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02755	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										02760	
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
George Martin Caspar						DATE MATED 2-14-69			19 6:30am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR		
Male	White	12-13-1882	86 YRS			Month 2-14-69 Day Year 19 6:40am			M		
7a BIRTHPLACE (State or foreign country)			7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Wash. D. C.			USA					Prince George's Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Internal Rev. (Rt)			Fed. Govt.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Maryland			Prince George's Hyattsville			YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER		
									6700 Bellcrest Road		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
Kasper A. Casper			Julia Ruppel								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS					
						Wm. H. Caspar, 4219 58th Ave. Blad.Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure										minutes	
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										over 3 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A M P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No.			City or Town County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			John Kehoe MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-14-69		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			Feb. 17, 1969			Congressional Cemetery			Washington D.C.		
24 FUNERAL DIRECTOR			ADDRESS			25 REC'D BY REG. STR.			25b REGISTRAR'S SIGNATURE		
Jakoma Funeral Home, J. A. Walter			254 Carroll St NW			FEB 18 1969			John Kehoe		

02761

CERTIFICATE OF DEATH

02756

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges County General Hospital</u>			d STREET ADDRESS <u>9122 Edmonston Road</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Chantker</u> Last <u>Chantker</u>			4 DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1969</u>		
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1907</u>	9 AGE (In years last birthday) <u>61 yrs</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Broker</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Simcha Chantker</u>			12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
14. MOTHER'S MAIDEN NAME <u>Unascertainable</u>			17 INFORMANT Address <u>3396 Curtis Drive, #302 Hillcrest Heights, MD</u> <u>Arthur Chantker</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) <u>Yes</u>		16 SOCIAL SECURITY NO <u>Unascertainable</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u> </u> (b) <u>Coronary artery disease</u> DUE TO <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21 I certify that (I) (this hospital) attended the deceased from <u>PAST 10 yrs</u> to <u>2-26, 1969</u> , that (I) (we) last saw the deceased alive on <u>JAN 1969</u> , and that death occurred at <u> </u> M, from causes on and on the date stated above.					
22a. SIGNATURE <u>Herbert L. Tanenbaum</u>		M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>HERBERT L. TANENBAUM</u>		22d. ADDRESS <u>4400 CONN. AVE. NW. WASH DC</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>Feb. 28, 1969</u>	23c NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden</u>	23d LOCATION (City or Town)	(County)	(State) <u>Falls Church, Virginia</u>
24 FUNERAL DIRECTOR <u>Donald M. Stein</u>		ADDRESS <u>232 Carroll</u>	25a REC'D BY REGISTRAR <u> </u>	25b REGISTRAR'S SIGNATURE <u> </u>	
Hebrew Memorial Funeral Home, St. NW Wash, DC		DATE <u>MAR 3 1969</u>	<u> </u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02762

CERTIFICATE OF DEATH

02757

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH			2b HOUR	
Margaret			LORRAINE	Clark	2/22/69 Month Day Year			8:02 P	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER YEAR MONTHS DAYS	
Female		White		FEB 7 1933		36 YRS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
WASHINGTON, D.C.		U.S.				Prince Georges County Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Capital Prince George		CASHIER		GIANT Food Co			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Prince Georges		Capital Heights		NO		6908 George Palmer Hwy.	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
JOSEPH T.			LEE, SR		FLORA B. DILLARD				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
NO.		217 28 8604		GERALD R. CLARK.		SARRE AS #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) Cardiac Arrhythmia									Minutes
DUE TO, OR AS A CONSEQUENCE OF									
(b) Healed Rheumatic Mitral Valvulitis with Mitral-									Years
DUE TO, OR AS A CONSEQUENCE OF									
(c) Stenosis.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from Sept 1968, to 2/22, 1969, that (I) (we) last saw the deceased alive on 2/19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE		22c DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e DATE SIGNED			
H. James Kurtz MD						2/25/69			
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
H. James Kurtz		RFD #1 Glenn Dale Md							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
BURIAL		FEB 26, 1969		GEORGE WASHINGTON MEM PK		HYATTSVILLE, MD			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
W. W. CHAMBERS INC.		SILVER SPRING, MD		FEB 26 1969		W. Chambers			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

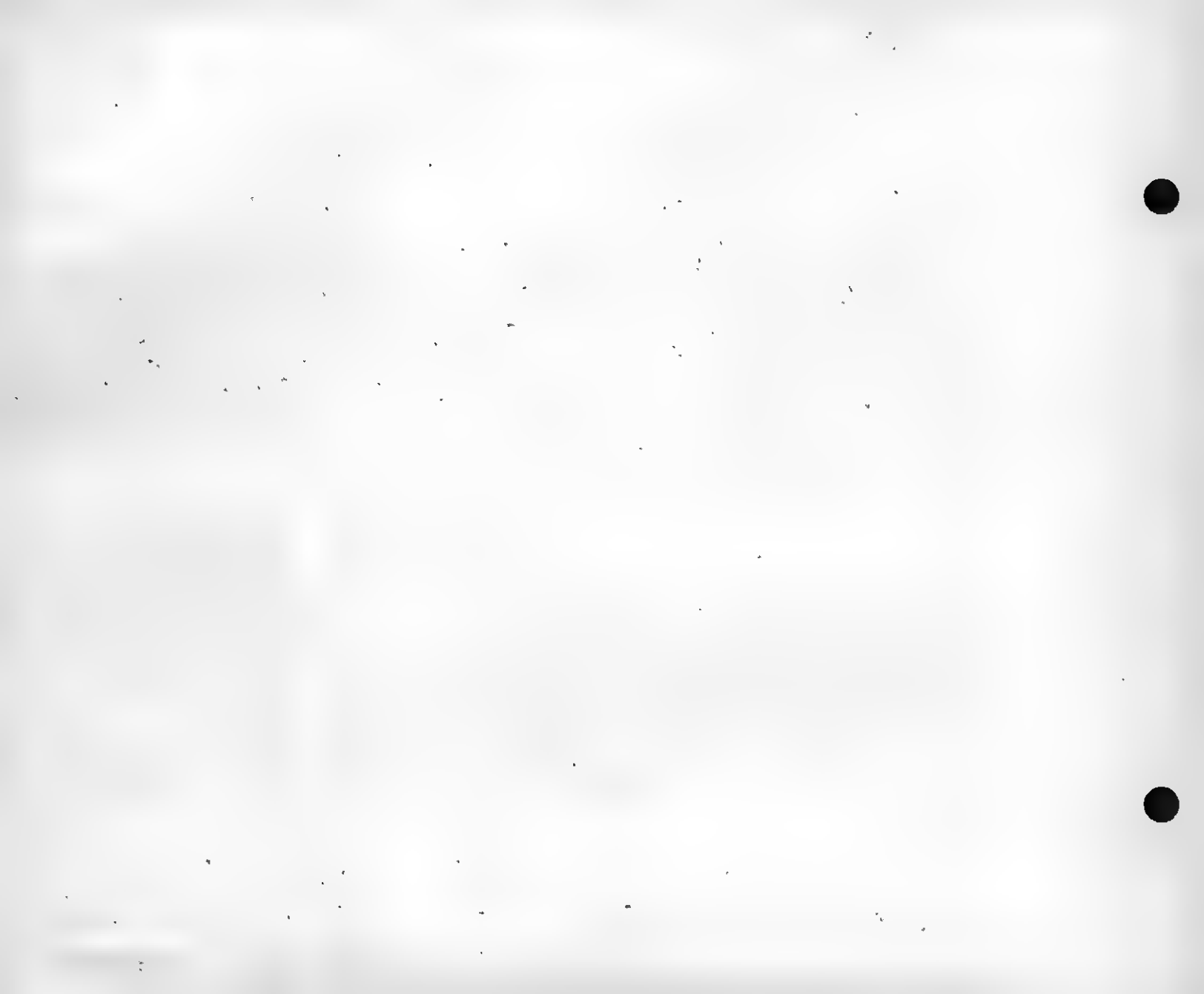


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (2-69)
30M REV 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Anna					Conway	2 22 69			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
F		Negro		01-06-24		45 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.A.				Prince George Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Md.		Benton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Waugh Chapel Rd.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Wesley			S.	Turner	Oda	Grays			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
						Earnest Conway, Benton Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Carcinoma</u>									
1830 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Carcinoma of colon</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		Carcinoma Colon			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> , 19 <u>69</u> , to <u>2/22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/20</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		22c. DATE SIGNED	
Robert T. Greenwald				M.D.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		2/22/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
ROBERT T. GREENWALD, M.D.				2412 Minn Ave S.E.		WASH. D.C.			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		2-26-1969		Mt. Taber		Chesterfield		Md.	
24. FUNERAL DIRECTOR		Address		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William Reese		Anna Md.		FEB 24 1969		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

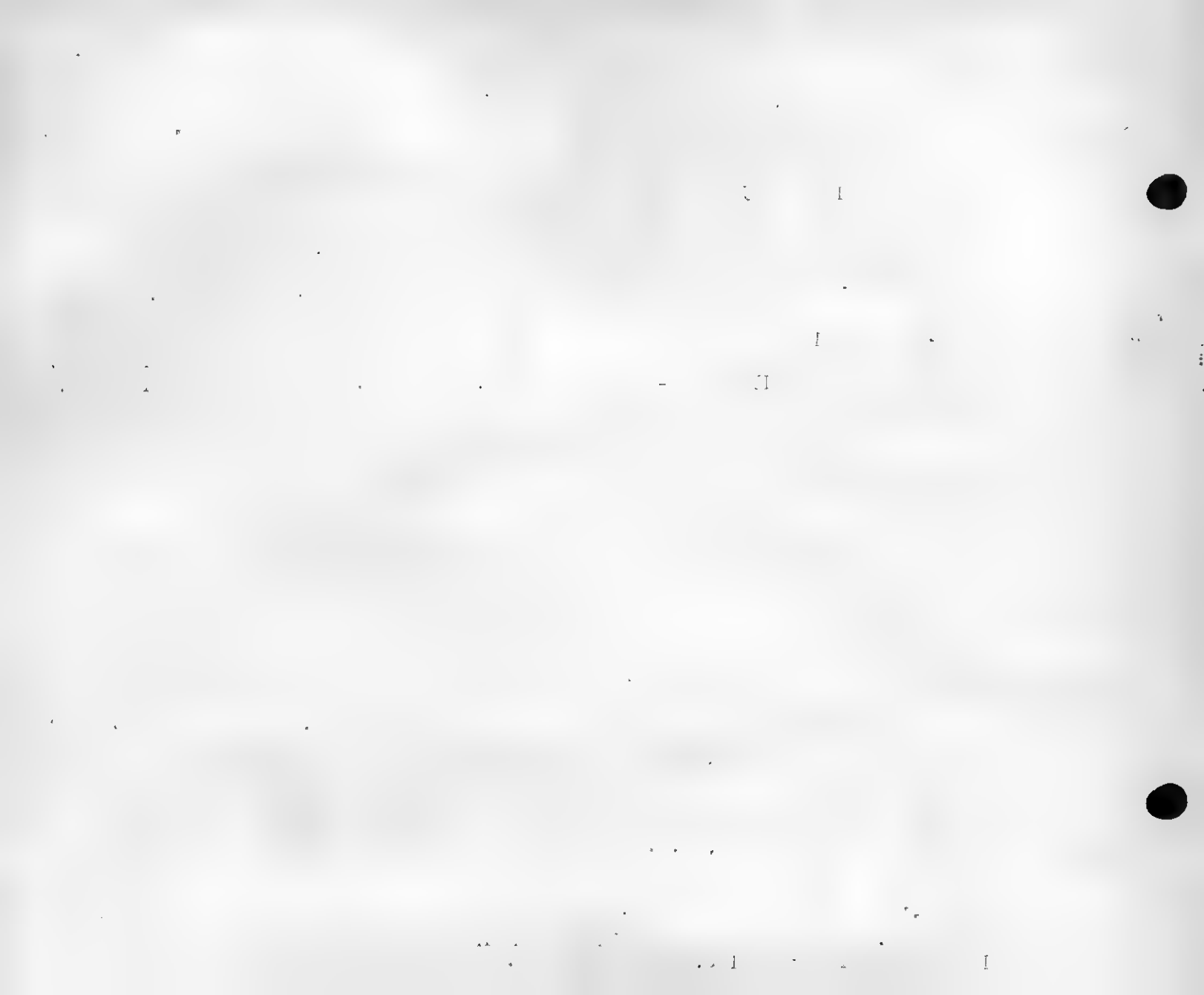
MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or print)			First ELIZABETH			Middle Orlan			Last Cullen			2a. DATE OF DEATH Month Day Year 2 24 69			2b. HOUR 9:25 AM		
3 SEX Female			4 RACE Caucasian			5 DATE OF BIRTH 8-21-95			6 AGE (In years last birthday) 73 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Washington, DC			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George Md								
10 CITY OR TOWN OF DEATH Hyattsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Librarian			12b KIND OF BUSINESS OR INDUSTRY of Rail Roads								
13a U.S. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D.C.			13b COUNTY --			13c CITY OR TOWN Washington			13d INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 7965 West Beach Dr., N.W.					
14 FATHER'S NAME First Middle Last Orlan C Cullen			15. MOTHER'S MAIDEN NAME First Middle Last Lucy Johnston			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) (If yes give war or dates of service) No						16b SOCIAL SECURITY NO			17 INFORMANT Wayward R. Addison		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas & wide spread metastasis</u>																	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac failure</u>												about 4 weeks					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senility.</u>												?					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State											
22a I certify that (I) (this hospital) attended the deceased from <u>November 1, 1968</u> , to <u>2-23-</u> , 1969, that (I) (we) last saw the deceased alive on <u>2-10-</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b SIGNATURE <u>T. Carreno</u>			DEGREE M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED <u>2-24-69</u>								
22d PHYSICIAN'S NAME (Type) <u>T. CARRENO M.D.</u>			22e ADDRESS <u>6101 New Hampshire Ave. Wash. D.C.</u>														
23a BURIAL CREMATION, RMOVA (Specify)			23b DATE <u>2-24-1969</u>			23c NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>			23d LOCATION (City or Town) (County) (State) <u>Prince Georges, Maryland</u>								
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>			ADDRESS <u>Sil. Spr. Md.</u>			25a REC'D BY REGISTRAR <u>FEB 27 1969</u>			25b REGISTRAR'S SIGNATURE <u>Elmer J. Yager</u>								

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses after 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-15. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>02765</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02760</div>									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Thomas Lee Dail						Month Day Year		6:15 p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	W	11 Dec 1928	40 YRS	MONTHS DAYS	HOURS MIN	Month Day Year		8:00 p.m.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
North Carolina		USA				Prince George Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Oxon Hill			Home			Carpenter			
13a. JSLAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.			Prince George Oxon Hill			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			
Jatha Dail			Cammie Lee Whitehurst			Yes <input type="checkbox"/> No <input type="checkbox"/> WW II			
16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
238-38-7755			Mrs. Oscar R. Johnson Oxon Hill, Md.			5106 Vinson St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun-shot wound of head									
DUE TO, OR AS A CONSEQUENCE OF									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
			6:15 p.m. 2 12 1969		Shot self.				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home		51-6 Vinson St. Oxon hill		P.G.		Md.	
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			2-12-69			
John Kehoe, M.D., Riverdale			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		16 Feb 69		Ayden Cemetery		Ayden North Carolina			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Ives Funeral Home, Inc. Arlington, Va.				DATE FEB 18 1969					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
02766 CERTIFICATE OF DEATH 02761												
1. DECEASED NAME (Type or print) Peter			First Middle Last			2a. DATE OF DEATH Month Day Year Feb 9 69			2b. HOUR 1055 M			
3 SEX Male		4. RACE Cau		5. DATE OF BIRTH Dec 29 1920			6. AGE (In years last birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.						
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) US Air Force				12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5200 Colony Road				
14. FATHER'S NAME Charles			First Middle Last			15. MOTHER'S MAIDEN NAME Anna Monteforte			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes		(If yes give year or dates of service) 20 Years		16b. SOCIAL SECURITY NO. 577-20-7696		17. INFORMANT Address Mrs. Kay Pete Dicarlo (same)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Broncho pneumonia										1 week		
1621 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. Carcinomatosis, bronchogenic										2 mo.		
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION Aug 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bronchogenic Carcinoma				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from August 1968 , to 9 Feb 1969 , that (I) (we) last saw the deceased alive on 9 Feb 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Wm. H. Williams						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 9 Feb 1969				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 11, 1969		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat.		23d. LOCATION (City or Town) (County) (State) Arlington Va.						
24. FUNERAL DIRECTOR Robert E. Wilhelm, Fun. Home						ADDRESS 4508 Suitland Rd. Suitland		25a. REC'D BY REGISTRAR FEB 17 1969		25b. REGISTRAR'S SIGNATURE J. Williams		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> Items 5, 7, & 8 Filled 3/4/69 kk 02767 02762 </div>									
1 DECEASED NAME (Type or print)			First Julius		Middle Dixon		Last Dixon		2a DATE OF DEATH
							<div style="display: flex; justify-content: space-between;"> Month February Day 20 Year 1969 </div>		2b HOUR A 10:50M
3. SEX Male		4 RACE Colored		5 DATE OF BIRTH February 22, 1911			6 AGE (in years last birthday) 57 YRS.		<div style="display: flex; justify-content: space-between;"> IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS </div>
7a. BIRTHPLACE (State or foreign country) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Prince George's			
10. CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George's Gen. Hosp.				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Pleasant		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 182 Damimler Dr.	
14. FATHER'S NAME			First First		Middle Middle		Last Last		15. MOTHER'S M.A.DEN NAME
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17 INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))									
<div style="display: flex; justify-content: space-between;"> <div> <p>PART 1 DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Exanguinating gastro-intestinal hemorrhage</p> <p>DUE TO, OR AS A CONSEQUENCE OF status three weeks post resection of esophagus for carcinoma with gastroesophageal</p> <p>(b) (anastomosis).</p> <p>DUE TO, OR AS A CONSEQUENCE OF (anastomosis).</p> <p>(c)</p> </div> <div> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATE									
19a DATE OF OPERATION Jan 22/1968		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of esophagus				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (the hospital) attended the deceased from Jan 10 , 19 69 , to Feb. 20 , 19 69 , that (I) (the hospital) last saw the deceased alive on 2/20/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George William Ware		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2/22/69			
22d PHYSICIAN'S NAME (Type) George William Ware, M.D.		22e ADDRESS 1835 Eye St., N.W., Washington, D.C. 20006							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 2-27-69		23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d LOCATION (City or Town) (County) (State) Shutland Md			
24. FUNERAL DIRECTOR Johnson + Johnson		ADDRESS 4804 12th Ave. N.W.		25a REC'D BY REGISTRAR FEB 27 1969		25b REGISTRAR'S SIGNATURE William B. Jones			

02768

02763

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) JOHN RAYMOND DOUGHERTY			2a. DATE OF DEATH Month 2 Day 15 Year 69			2b. HOUR 8:52 P M	
3. SEX Male		4. RACE W		5. DATE OF BIRTH 4/10/1918		6. AGE (in years lost birthday) 50 YRS.	
7a. BIRTHPLACE (State or foreign country) Wash., D. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Equipment Operator		12b. KIND OF BUSINESS OR INDUSTRY Gov't.	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md		13b. COUNTY Prince Georges		13c. CITY OR TOWN Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER Box 4251 Dower House Rd.		14. FATHER'S NAME First John R. Middle Dougherty		15. MOTHER'S MAIDEN NAME First Hattie Middle Sheaffer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO.		17. INFORMANT Mary A. Dougherty		Address Box 4251 Dower House Rd., Upper Marlboro	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Myocardial Infarct 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 1.2 yrs?						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/12 , 19 69 , to 2/13 , 19 69 , that (I) (we) lost saw the deceased alive on 2/13 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Frank T. Fedor MD				22c. DATE SIGNED 2/16/69			
22d. PHYSICIAN'S NAME (Type) FRANK T. FEDOR MD				22e. ADDRESS 4201 CATHEDRAL AVE N.W. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/19/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Rd., S.E., Suitland, Md. 20023				25a. REC'D BY REGISTRAR FEB 20 1969		25b. REGISTRAR'S SIGNATURE William J. Judge	

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02769

02762

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Emma L. Doyle			2a DATE OF DEATH Month February Day 6 Year 1969			2b HOUR 5:45 PM			
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH 9-1-81		6 AGE (In years last birthday) 87 YRS.		7 IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN	
7a BIRTHPLACE (State or foreign country) Chicago Ill.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Co. Md.			
10 CITY OR TOWN OF DEATH HURTSMIRE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL HOSPITAL 1432 W. SALEM ST. APT. 401		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOME-MAKER		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD		13b CITY OR TOWN WASH., D.C.		13c INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 1837-Monroe St. N.E.			
14 FATHER'S NAME First LEONARD Middle A. Last LANGE			15. MOTHER'S MAIDEN NAME First FANNIE Middle CARLILE Last CARLILE						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO 5 79-68-356		17 INFORMANT Dr. Michael J. K. K. K.		Address Croft House 4712 K. St. N.E.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Aspiration PNEUMONIA 4107 DUE TO, OR AS A CONSEQUENCE OF (b) Probable myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. 10 Month 2 Day 21 Year 1968 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No 2-6 City or Town WASH., D.C. County D.C. State D.C.					
22a. I certify that (1) (this hospital) attended the deceased from 10-21 , 19 68 , to 2-6 , 19 69 , that (1) (we) lost saw the deceased alive on 2-6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death									
22b SIGNATURE Francis Chutee M		22c DEGREE M.D.		22d ADDRESS 2500 CALVERT ST NW WASH., D.C.		22e DATE SIGNED 2-6-69			
22d. PHYSICIAN'S NAME (Type) Francis Chutee M		22e ADDRESS 2500 CALVERT ST NW WASH., D.C.		22f LOCATION (City or Town) (County) (State) Wash., D.C.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 2/10/69		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d LOCATION (City or Town) (County) (State) Wash., D.C.			
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc.		24b ADDRESS Mt. Rainier, Maryland		25a REC'D BY REGISTRAR FFB 13 1009		25b REGISTRAR'S SIGNATURE Francis Chutee M			



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02770 Item 6 File 3409 2/20/69 kk										02765	
1 DECEASED NAME (Type or print) Wesley, Drake						2a. DATE OF DEATH Month 2 Day 3 Year 1969			2b. HOUR 5:50 A		
3 SEX White Male		4. RACE White Male		5 DATE OF BIRTH 01/07/04		6 AGE (In years last birthday) 64 YRS.		7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Iowa		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md.					
10 CITY OR TOWN OF DEATH Cheverly				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Hardware	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Prince Geo.		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4711 Queensbury Rd	
14. FATHER'S NAME First Middle Last Josiah L Drake				15. MOTHER'S MAIDEN NAME First Middle Last Anna M Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)				16b. SOCIAL SECURITY NO 484 01 1575		17. INFORMANT Address Elma I Drake Riverdale, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertension and shock. 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Kimmelsteil Wilson Disease. DUE TO, OR AS A CONSEQUENCE OF (c) Labile Hypertension.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arterio-sclerotic Heart Disease.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12/17/68 , 19____, to 2/3/69 , 19____, that (I) (we) lost saw the deceased alive on 2/3 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE [Signature]						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/3/69			
22d. PHYSICIAN'S NAME (Type) P. C. Xavier, M.D.						22e. ADDRESS Prince George's Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 6, 1969		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md					
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR FEB 7 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Agnes A. Duffy					2a. DATE OF DEATH 2/12/69			2b. HOUR 12:25M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug. 7, 1890		6. AGE (In years last birthday) 78		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work'ng life, even if retired) Store Owner		12b. K. NO. OF BUSINESS OR INDUSTRY Self			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Cheverly		13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5616 Greenleaf Road	
14. FATHER'S NAME Henry Duffy			15. MOTHER'S MAIDEN NAME Ann Campbell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO 577 62 3214		17. INFORMANT Margaret M. Doerner Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Right Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1968 to Feb 12, 1969 , that (I) (we) last saw the deceased alive on Feb 11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. Richard Lilly, M.D.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-12-69		
22d. PHYSICIAN'S NAME (Type) J. Richard Lilly, M.D.					22e. ADDRESS 4410 74th Avenue, Hyattsville, Md.				
23a. BURIAL, CREMATION, OR OTHER (Specify) Burial		23b. DATE 2/14/69		23c. NAME OF CEMETERY OR CREMATORY St. Ann's Cemetery		23d. LOCATION (City or Town) (County) (State) Freeland Pa.			
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR FEB 14 1969		25b. REGISTRAR'S SIGNATURE William B. O'Quinn		

02772

CERTIFICATE OF DEATH

0276,

1. DECEASED NAME (Type or print) Johnnie			First Middle Last Edwards			2a. DATE OF DEATH February 15 ^{Month} 69 ^{Day} Year			2b. HOUR 8:00PM		
3 SEX Male			4 RACE White.			5. DATE OF BIRTH 09-10-26			6 AGE (In years last birthday) 42 YRS.		
7a BIRTHPLACE (State or foreign country) Rockville, Md.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md		
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen. Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY Prince George's			13c CITY OR TOWN Greenbelt			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME Ralph			First Middle Last Edwards			15 MOTHER'S MAIDEN NAME Mollie Mae			First Middle Last Fugett		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) Yes			16b SOCIAL SECURITY NO 218-20-1328			17 INFORMANT Bernadine Edwards			Address 7174 Hanover Parkway - Greenbelt		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis, Right and Left DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (X) (this hospital) attended the deceased from Feb. 15 , 19 69 , to Feb. 15 , 19 69 , that (X) (we) last saw the deceased alive on Feb. 15 , 19 69 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b SIGNATURE Luis Bentolila						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c DATE SIGNED 2-16-69		
22d. PHYSICIAN'S NAME (Type) Luis Bentolila, M. D.						22e ADDRESS Prince Georges Gen. Hosp., Cheverly, Md.					
23a BURIAL (CREMATION, REMOVAL) (Specify)			23b DATE Feb. 19-1969			23c NAME OF CEMETERY OR CREMATORY UNION CEMETERY			23d LOCATION (City or Town) (County) (State) Greenbelt Prince Georges Md		
24 FUNERAL DIRECTOR Arthur Walters			ADDRESS 254 Green St.			25a REC'D BY REGISTRAR FEB 19 1969			25b REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02773

CERTIFICATE OF DEATH

02763

1. DECEASED-NAME (Type or print) Kenneth P. Eggleston			2a. DATE OF DEATH Month 2 Day 6 Year 1969			2b. HOUR 10:15 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 01/21/14		6. AGE (In years last birthday) 55 YRS.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County	
10. CITY OR TOWN OF DEATH Cheverly,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Announcer		12b. KIND OF BUSINESS OR INDUSTRY Radio	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Geo. Cheverly		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2505 Valley Way	
14. FATHER'S NAME Charles		15. MOTHER'S MAIDEN NAME Lulu Krass					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (Yes give war or dates of service)		16b. SOCIAL SECURITY NO. 072-03-1446		17. INFORMANT David Eggleston (Same as # 13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrolyte Imbalance 5601 DUE TO, OR AS A CONSEQUENCE OF (b) Paralytic Ileus with: DUE TO, OR AS A CONSEQUENCE OF A. Hypo-Kalemia B. Hypo-Natremia (c) C. Hypo Chloremia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 1-31-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary Illness		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 30, 1969 to Feb 6, 1969 , that (I) (we) lost saw the deceased alive on Jan 6, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dayton O Watkins		22c. DATE SIGNED 2-6-69		22d. ADDRESS 5318 Annapolis Rd Beedinsburg Md			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 2-10-69		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR F. Gasch's Sons 4739 Balt. Ave. Hyattsville, Md.				25a. REC'D BY REG STRAR FEB 11 1969		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Items 13 & 23 FilmG-11

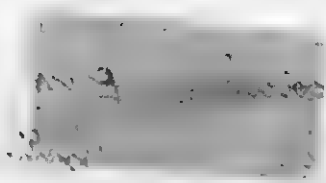
4/2/69 kk & Item 1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02763

1 DECEASED NAME (Type or print) <i>Elizabeth</i> First <i>North</i> Middle <i>Evans</i> Last		2a. DATE OF DEATH <i>2</i> Month <i>18</i> Day <i>1969</i> Year		2b. HOUR <i>6:45</i> P.M.	
3. SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>11/18/90</i>	
7a BIRTHPLACE (State or foreign country) <i>Rhode Island</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <i>Adelphi, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bank Branch Home</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Bank Branch Home</i>		13b CITY OR TOWN <i>Adelphi</i>		13c STREET AND NUMBER <i>11 Allison Ave.</i>	
14. FATHER'S NAME First <i>Charles</i> Middle <i>Tralton</i> Last <i>Tralton</i>		15. MOTHER'S MAIDEN NAME First <i>Ida</i> Middle <i>Tralton</i> Last <i>Tralton</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>	
16b SOCIAL SECURITY NO. <i>none</i>		17 INFORMANT <i>Son Jack Evans</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>12 yrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (this hospital) attended the deceased from <i>1-8</i> , 19 <i>65</i> , to <i>2-18</i> , 19 <i>69</i> , that (we) last saw the deceased alive on <i>2-18</i> , 19 <i>69</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>R.D. Bauer M.D.</i>		22c. DATE SIGNED <i>2/18/69</i>		22d. PHYSICIAN'S NAME (Type) <i>R.D. Bauer, M.D.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>2-21-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>North Burial Grounds</i>	
23d. LOCATION (City or Town) (County) (State) <i>North Providence, Rhode Isl.</i>		24a. RECEIVED BY REGISTRAR <i>FEB 21 1969</i>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First <i>Edward</i>		Middle <i>J.</i>		Last <i>Fallon</i>		2a DATE OF DEATH <i>Feb. 4th 1969</i>		
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>30 March 1910</i>			6 AGE (In years lost birthday) <i>58</i> YRS		7 UNDER 1 YEAR MONTHS DAYS 8 UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i>					
10 CITY OR TOWN OF DEATH <i>Hyattsville</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>2400 Queens Chapel Road</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Accountant C.A.</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Gov't.</i>			
13a USUAL RESIDENCE (Where deceased admission) STATE <i>Md.</i>		13b COUNTY <i>Pr. Geos.</i>		13c CITY OR TOWN <i>Hyattsville</i>		13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>2400 Queens Chapel Road</i>			
14. FATHER'S NAME First <i>Anthony</i> Middle <i>--</i> Last <i>Fallon</i>			15. MOTHER'S MAIDEN NAME First <i>Josephine</i> Middle <i>--</i> Last <i>Rosa</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (or, of unknown) <i>Yes</i>		16b SOCIAL SECURITY NO <i>579-28-9173</i>		17. INFORMANT <i>Rita N. Fallon</i> Address <i>Hyattsville, Md.</i> <i>2400 Queens Chapel Rd.</i>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of the Liver</i>										<i>4 months</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Primary Carcinoma of the Urinary Bladder</i>										<i>8 months</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Jaundice</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION											
19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>June, 1961</i> , to <i>Feb. 4, 1969</i> , that (I) (we) lost saw the deceased alive on <i>Feb. 1</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Bertram F. Schaefer</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <i>Feb. 4, 1969</i>					
22d PHYSICIAN'S NAME (Type) <i>Bertram F. Schaefer</i>				22e ADDRESS <i>1780 M 255 AVE - N.W. - Wash. D.C.</i>							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>2-7-1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d LOCATION (City or Town)		(County)		(State)	
<i>Burial</i>		<i>2-7-1969</i>		<i>Parklawn Cemetery</i>		<i>Rockville</i>		<i>Montgomery</i>		<i>Md.</i>	
24 FUNERAL DIRECTOR <i>C. Glen Carter</i>				ADDRESS <i>Sil. Spr., Md.</i>		25a REGISTERED DATE <i>FEB 10 1969</i>		25b REGISTRAR'S SIGNATURE <i>James Judge</i>			
26 REGISTRAR'S NAME <i>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</i>											



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02776

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02771

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year			2b HOUR
William			C	Fast			2-19-69 19 8:40am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	10-2-1887	81 YRS					2 19 69	19 8:40am
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Wisconsin		U S A				Prince George's Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George Hospital			Mechanic			Fairbanks Co
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before)			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Prince George's		Beltsville			11712 Emack Road	
4 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Henry P Fast						Henrietta Rindfleisch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
yes			391 07 8828		Robert Fast		Beltsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u>									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
(c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Fracture neck of right femur - 2-4-69</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
2-18-69			Fracture neck of right femur				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
CAUSE OF DEATH			9:00am 2-4-19 69		Fell at home				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State
			home		same as # 13				
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-20-69			
John Kehoe MD Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)
Burial			Feb 22, 1969		Oakwood Cemetery		Beloit		Wisconsin
24 FUNERAL DIRECTOR					ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE
F. Gasch's Sons Hyattsville, Md.							FEB 24 1969		W. C. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Joan Renee Fay						2a. DATE OF DEATH February Month 28 Day 69 Year			2b. HOUR 1:45 a.m.		
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH 12 March 1929		6. AGE (In years last birthday) 39 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Andrews AFB			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Prince Geo.		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5546 Woodland Blvd		
14. FATHER'S NAME First Middle Last Herbert S Devereaux				15. MOTHER'S MAIDEN NAME First Middle Last Agnes T Kane							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO 579-30-2227			17. INFORMANT Husband, George Fay, item 13e Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain Involvement = Hodgkin's Disease DUE TO, OR AS A CONSEQUENCE OF (b) Hodgkin's Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks 3 1/2 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that XX (this hospital) attended the deceased from 17 January, 1969 to 28 February 69 , that XX (we) last saw the deceased alive on 28 February 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above XX (we) (d d) (XX XX) view the body after death.											
22b. SIGNATURE David S Rosenthal MD DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED 28 February 69					
22d. PHYSICIAN'S NAME (Type) David S Rosenthal MD						22e. ADDRESS Malcolm Grow USAF Hospital, Andrews AFB Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-4-1969		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5140 Wisc. Ave. N.W. Wash. D.C. 20016						25a. REC'D BY REGISTRAR MAR 6 1969		25b. REGISTRAR'S SIGNATURE William H. ...			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 411 Maryland State Department of Health
4-10-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02778

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02773

1 DECEASED NAME (Type or Print) Sean Padraig Finnin			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 2-3-69 192:00pm			2b HOUR		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 10-12-1968	6 AGE (in years last birthday) 4 YRS	IF UNDER 24 HRS MONTHS DAYS 4	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 2 Day 3 Year 69 193:03pm		
7a BIRTHPLACE (State or foreign country) Wash. D. C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before) Maryland		13b COUNTY Prince George's Hyattsville		13c CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3421 Tulane Drive		
14 FATHER'S NAME First Michael J. Middle J. Last Finnin			15 MOTHER'S MAIDEN NAME First JoAnn Middle Stiles Last Stiles					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b SOCIAL SECURITY NO		17 INFORMANT Michael J. Finnin (Father) Same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 Acute bronchitis and bronchiolitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SDII DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.		22b DATE SIGNED 2-4-69		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 2-5-69		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION (City or Town) (County) (State) Suitland Maryland		23e. REC'D BY REG FEB 7 1969
24 FUNERAL DIRECTOR Francis G. Collins 500 University Blvd. W. Silver Spring, Maryland.				REGISTER'S SIGNATURE Quincy				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO CORRECTIONS: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02779 CERTIFICATE OF DEATH 02775

1. PLACE OF DEATH Prince George's a. COUNTY 805/115 Sand Lane / Capital Heights b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Capital Heights c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Capital Heights d. STREET ADDRESS 805 52nd Ave - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First Middle Last J RENE M. Fisher		4. DATE OF DEATH Month Day Year Feb 6 1969		5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 Feb 1883		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N. W.				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Ellis E. Meeks						14. MOTHER'S MAIDEN NAME Mildred A. Smead																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. —				17. INFORMANT Mrs. Umberto Di Pietro Address															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 188 X Adenocarcinoma of bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive cardiac disease INTERVAL BETWEEN ONSET AND DEATH unknown																							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov 3, 1968, to Feb 6, 1969, that (I) (we) last saw the deceased alive on Feb 5, 1969, and that death occurred at 3:50 P.M. from the causes and on the date stated above.																							
22a. SIGNATURE Henry G. Hadley				22b. DATE SIGNED Feb 6 69				22c. PHYSICIAN'S NAME (Type) HENRY G. HADLEY				22d. ADDRESS 4601 NICHOLS AVE SE Washington											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8 Feb 69				23c. NAME OF CEMETERY OR CREMATORY Lynnhurst Meth Ch. Cm Landmark, Va.				23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR Mrs. Funeral Home				25a. ADDRESS 2847 Wilson Blvd				25b. REC'D BY REGISTRAR FEB 7 1969				25c. REGISTRAR'S SIGNATURE											

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 shall be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02775	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										02780	
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> 2-12-69 191:35pm M		
John			Franklin								
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year 2 12 69 191:40pm M		
Male	Negro	3-24-1902		66 YRS							
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md	
Md		U. S. A.				Prince George's					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Retired			Sanitor		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER			
Maryland				Laurel		YES <input type="checkbox"/> NO <input type="checkbox"/>		Highridge Place			
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
William W. Franklin			Mattie Weldon								
16a WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
No			None			Mattie Franklin			307 Linden st		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus - over 1 yr.											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A. M. P. M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe MD EXAMINER'S NAME (Type)				Rivendale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE 2/17/69		23c NAME OF CEMETERY OR CREMATORY Caevee Mem. Cem.		23d LOCATION (City or Town) (County) (State) Maierkirk, Md.			
24 FUNERAL DIRECTOR H.S. Washington & Sons 4925 Denne Ave NE DC						25a REC'D BY REGISTRAR DATE FEB 19 1969		25b REGISTRAR'S SIGNATURE			



02781

CERTIFICATE OF DEATH

02776

1. DECEASED-NAME (Type or print) Richard B. Franklin, Junior			2a. DATE OF DEATH Month 2 Day 9 Year 1969			2b. HOUR 10:35	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 08/18/24		6. AGE (In years lost birthday) 44 YRS	
7a. BIRTHPLACE (State or foreign country) WASHINGTON DC		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Govt. Classified		12b. KIND OF BUSINESS OR INDUSTRY Dept of Defense - A. R. Force	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyatsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME RICHARD B. FRANKLIN		15. MOTHER'S MAIDEN NAME EMMA SULLIVAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO 578245636		17. INFORMANT MRS VIRGINIA J. FRANKLIN Address SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Left Ventricular Rupture DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12-8-1968 to 2-9-1969 , that (I) (we) lost the deceased alive on 2-9-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Oliver B. Bond		22c. ADDRESS 7420 Marlboro Pike, Forestville Maryland		22d. PHYSICIAN'S NAME (Type) Oliver Bond, M.D.		22e. DATE SIGNED 2/10/69	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-13-1969		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATL CEM.		23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR W.H. CHAMBERS CO. RIVERDALE, MARYLAND		25a. DECEASED BY REGISTRAR FEB 13 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR A
Joseph H. Frantum						2/3/69			11:40
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		04/08/06			62		YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md		U S A				Prince George's County Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George's Hospital			Steam-Fitter		Construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince Geo. Landover Hills					3904 70th Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Joseph H Frantum			Clara B Langville						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no					Martha C Frantum		Landover Hills, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ileo-colic Cecum Fistula</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Esophagus, surgically treated.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/3/68</u> , 19 <u>68</u> , to <u>2/3/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/3/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Jerome Sandler</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>2/4/69</u>		
22d. PHYSICIAN'S NAME (Type) Jerome Sandler, M.D.					22e. ADDRESS Prince George's Hospital				
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb 5, 1969		Frantum-Langville Cemetery		Arnold		Anna Arundel Md.	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons			Hyattsville Md.			FEB 7 1969		<u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02783		02778		CERTIFICATE OF DEATH					
1. DECEASED NAME (Type or print) First Middle Last ANNIE FREED			2a. DATE OF DEATH Month Day Year FEB 1 1969			2b. HOUR 4:22 PM			
3. SEX F		4. RACE CAU		5. DATE OF BIRTH 5 APR 1875		6. AGE (In years last birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) PENN		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES			
10. CITY OR TOWN OF DEATH ANDREWS AFB MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAF HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN MARLOW HTS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2600 KEATING STREET	
14. FATHER'S NAME First Middle Last WILLIAM A SMILEY			15. MOTHER'S MAIDEN NAME First Middle Last MARTHA ALICE ADAIR						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 162 22 1016		17. INFORMANT Address MRS L.B. REYNOLDS 2600 KEATING ST MARLOW HTS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CVA (2) CEREBRAL HEMISPHERE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard C. Lunsell, M.D.				22c. DATE SIGNED 1 Feb. 69		22d. PHYSICIAN'S NAME (Type) Richard C. Lunsell, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/3/69		23c. NAME OF CEMETERY OR CREMATORY Hershey Cemetery		23d. LOCATION (City or Town) (County) (State) Hershey Dauphin Co. Pa.			
24. FUNERAL DIRECTOR ADDRESS Hershey Funeral Home Hershey, Penn. 17033				25a. REGD BY REGISTRAR FEB 19 1969		25b. REGISTRAR'S SIGNATURE			

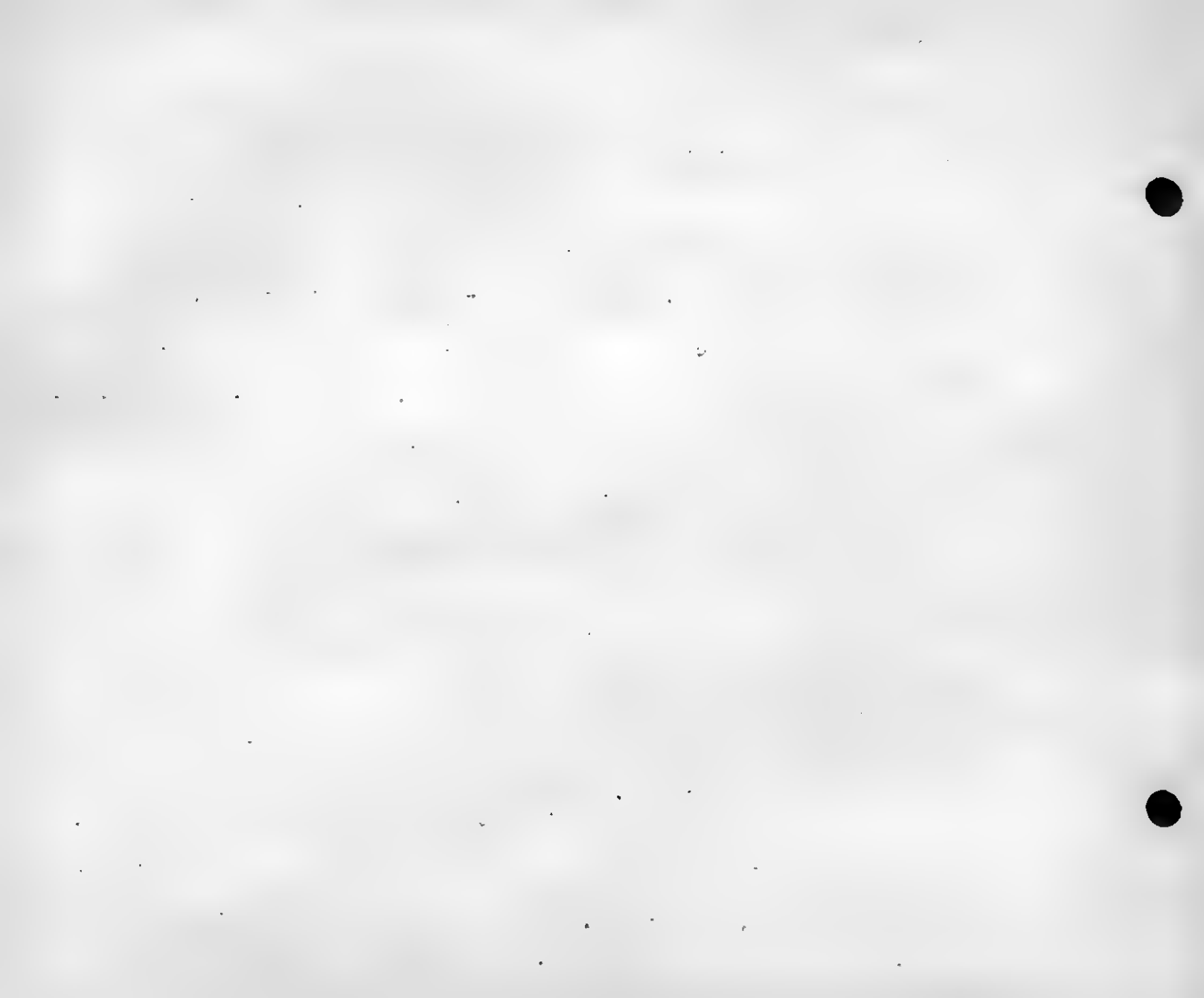
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA 15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																				
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																				
CERTIFICATE OF DEATH																				
1 DECEASED NAME (Type or print)			First Robert			Middle Floyd			Last Frick			2a. DATE OF DEATH Month Day Year Feb. 26, 1969			2b. HOUR P 1:46 M					
3. SEX Male			4 RACE White			5. DATE OF BIRTH 10/2/25			6 AGE (In years lost birthday) 43 YRS.			7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS. HOURS MIN.						
7a BIRTHPLACE (State or foreign country) Pa			7b. CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md											
10. CITY OR TOWN OF DEATH Cheverly						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. General Hosp.						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland						13b COUNTY Prince George's						13c. CITY OR TOWN Bladensburg			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 5013 Townsend Street		
14. FATHER'S NAME First Middle Last H Floyd Frick						15. MOTHER'S MAIDEN NAME First Middle Last Janet Ruth Jaynes														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes						(If yes give year or dates of service) W W 11						16b. SOCIAL SECURITY NO. 204 14 8198			17. INFORMANT Dorothy G. Frick			Address Bladensburg, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leemae's cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with Hepatic failure</u> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																				
19a. DATE OF OPERATION 2/17/69			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding esophageal varices						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1969, to Feb 26, 1969, that (I) (we) last saw the deceased alive on Feb 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <u>William B. Gunther</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>															22c. DATE SIGNED 2/26/69					
22d. PHYSICIAN'S NAME (Type) William B. Gunther, M.D.						22e. ADDRESS 6899 Lyle Street, Lanham, Maryland														
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial			23b. DATE March 1, 1969			23c. NAME OF CEMETERY OR CREMATORY National Memorial Park			23d. LOCATION (City or Town) (County) (State) Falls Church Fairfax Va											
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						ADDRESS			25a. FILED BY REGISTRAR MAR 4 1969			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>								

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print) First Middle Last JACOB GABRIEL						2a DATE OF DEATH Month Day Year FEB. 16 1969			2b HOUR 4:55 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11-28-1884		6. AGE (In years last birthday) YRS 84		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) GERMANY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.						
10 CITY OR TOWN OF DEATH GREEN BELT		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7110 GREENBELT RD. DRESS DESIGNER				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CLOTHING			12b KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution on. Residence before admission) STATE MARYLAND			13b COUNTY PRINCE GEORGE			13c CITY OR TOWN MATTSVILLE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 9109 15th AVE		
14 FATHER'S NAME First Middle Last GERSON - GABRIEL				15 MOTHER'S MAIDEN NAME First Middle Last L EMMA (UNK)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO. 197-03-6312A		17. INFORMANT Gertrude Schocker (saw her 13)			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 15.38 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF COLON DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF COLON Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) UREMIA CIRRHOSIS OF LIVER TRACHEOSTOMY												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF COLON				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a I certify that (I) (this hospital) attended the deceased from 8 Feb , 19 69 , to 16 Feb , 19 69 , that (I) (we) last saw the deceased alive on 16 Feb , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE Thomas P Fogarty						DEGREE PHYS		MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 16 Feb 69		
22d PHYSICIAN'S NAME (Type) THOMAS P FOGARTY						22e ADDRESS						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 3/17/69		23c NAME OF CEMETERY OR CREMATORY MONTEFIORE CEM		23d LOCATION (City or Town)		(County)		(State)		
24. FUNERAL DIRECTOR Goldberg Funeral Home		ADDRESS 4217-9-Kod		25a REC'D BY REGISTRAR FEB 19 1969		25b. REGISTRAR'S SIGNATURE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
304 REV

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 02786 CERTIFICATE OF DEATH 02781 </div>									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b. HOUR
Grace			R. Gardner			2/5/69 Month Day Year			4:15 M
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		10/06/81		87 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Albany NY		U.S.				Prince George's County Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's Hospital		Secretary		State of N.Y.			
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before adm ssion) STATE			13b. COUNTY		13c CITY OR TOWN		13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			Prince Geo.		Laurel		YES <input type="checkbox"/> NO <input type="checkbox"/>		8807 Hunting Lane
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Lewis			Gulbra			Elizabeth Schaffer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
			107-16-6206		Name		Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Tamponade due to</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>Dissecting aneurysm of Ascending Aorta with</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Rupture into Pericardial Sac.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>02/04/69</u> 19 <u>69</u> , to <u>2/5/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE <u>Edwin J. Jensen MD.</u> DEGREE					ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>2/5/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Edwin J. Jensen, M.D.</u>					22e. ADDRESS				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Cremation		2/7/69		Carmichael		Carmichael		Ind	
24. FUNERAL DIRECTOR					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Arnold					FEB 10 1969		Edwin J. Jensen		

FOR STATE
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1055 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

Item 22 Film 410 3-26 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02782	
02787 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) First Middle Last Floyd Edgar Gartrell						2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 2-20-69 19 3:40pm		2b HOUR			
3 SEX Male	4 RACE White	5. DATE OF BIRTH 5-7-1907	6 AGE (in years last birthday) 61 YRS	7 UNDER YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month 2 Day 20 Year 69 19 7:10pm		2d HOUR			
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md					
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George Hospital		12a U.S.A. OCCUPATION (Kind of work done during most of work ng l, fe. even if retired) Bus Operator		12b. KIND OF BUSINESS OR INDUSTRY					
13a USUAL RES DENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Prince George's		13c CITY OR TOWN Cottage City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3707 40th. Place			
14. FATHER'S NAME First Middle Last Thomas B. Gartrell				15 MOTHER'S MAIDEN NAME First Middle Last Edith Hess							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 578-10-5432		17 INFORMANT ADDRESS Mrs. Hazel A. Gartrell Same As #13.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 8:32pm 2-20-19 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot by discharge of .12 gauge shot gun.							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory office building, etc.) Bedroom of home		21f LOCATION Street or R.F.D. No City or Town County State same as #13							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)				22b DATE SIGNED 2-21-69			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 2/24/1969		23c NAME OF CEMETERY OR CREMATORY Taylorsville Cemetery				23d LOCATION (City or Town) (County) (State) Carroll Co., Md.			
24. FUNERAL DIRECTOR C.M. Waltz, Box 241, Sykesville, Md.				25a REC'D BY REGISTRAR DATE FEB 25 1969		25b REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02788

02783

1. DECEASED-NAME (Type or print) Mazel M. GERTSCH			2a. DATE OF DEATH Month Feb. Day 7 Year 1969			2b. HOUR 7:45 PM	
3 SEX Female		4. RACE White		5. DATE OF BIRTH 3-27-1899		6. AGE (in years last birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md	
10. CITY OR TOWN OF DEATH Adelphi		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hillhaven 3120 Powdermill Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) H. wife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. CITY OR TOWN Prince George Beltsville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 11619-35 Ave.	
14. FATHER'S NAME First Middle Last Thomas Jefferson Sams			15. MOTHER'S MAIDEN NAME First Middle Last Ida Mae Quinn				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 213-56-8574		17. INFORMANT Mr Edward GERTSCH		Address 11619-35 Ave Beltsville.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis - hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Aortic aneurysm - rupture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hr. 18 yrs. 5 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Heart							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? - YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (this hospital) attended the deceased from Aug 1963 , to 2-7 1969 , that (I) (we) last saw the deceased alive on 2-7 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R.D. Bauer M.D.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-7-69			
22d. PHYSICIAN'S NAME (Type) R.D. Bauer, M.D.		22e. ADDRESS 2513 Buck Lodge Rd. Adelphi P.D. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 11, 1969		23c. NAME OF CEMETERY OR CREMATORY St John's Cemetery		23d. LOCATION (City or Town) (County) (State) Beltsville Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 13 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

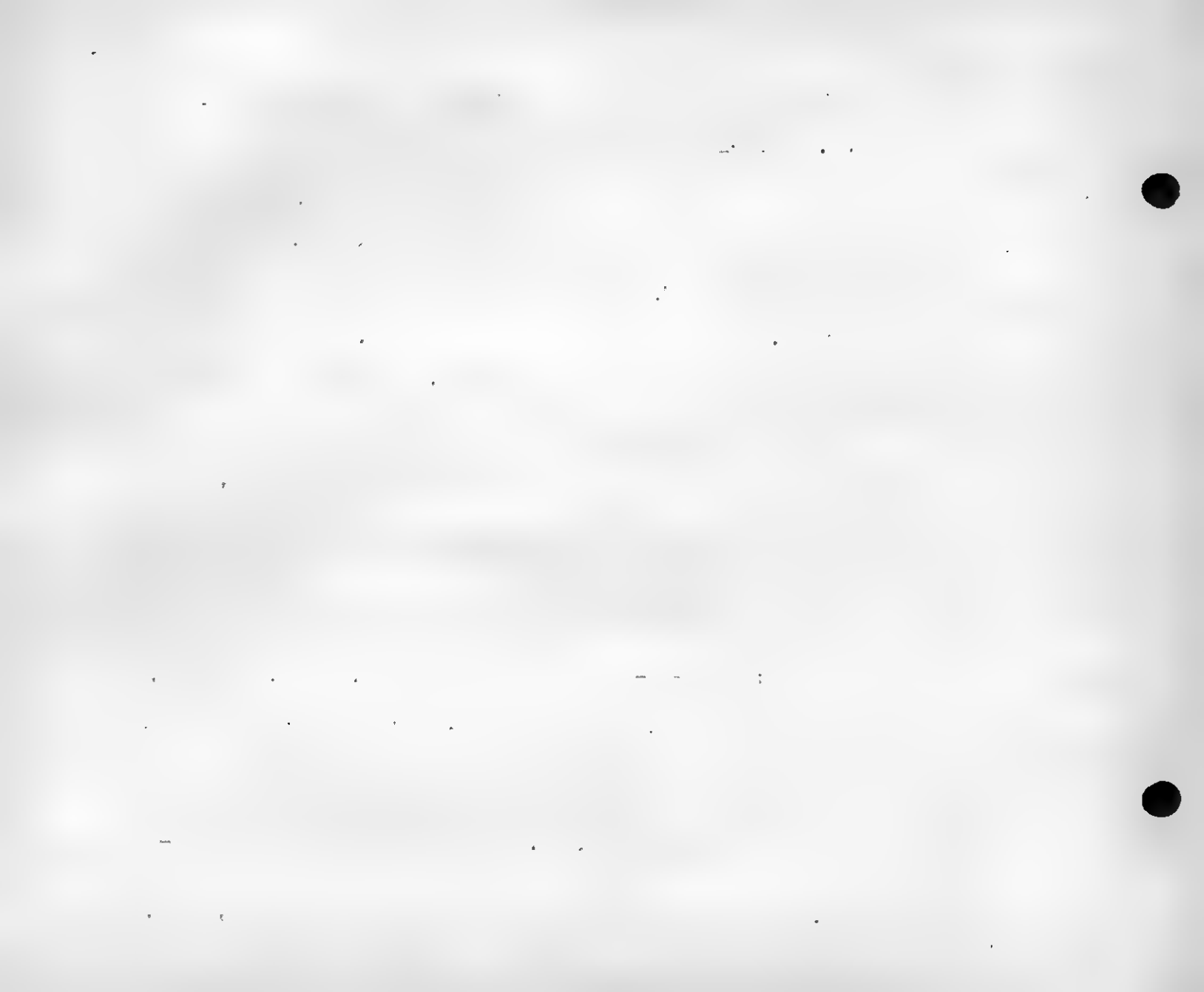
FOR STATE HEALTH DEPT.

02789

02784

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
John William Gifford						ESTIMATED DATE OF DEATH			19 9:00pm		
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d HOUR
Male	White	1-22-1950	19 YRS	MONTHS	DAYS	HOURS	MIN.	Month 2 Day 19 Year 69			19 8:45am M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
DC		USA				Prince George's Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Construction Work					
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER		
Maryland			Prince George's			YES <input type="checkbox"/> NO <input type="checkbox"/>			5043 Leverette Street		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
John E. Gifford			Doris F. Bivens								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
No						Doris E. Gifford			5043-Leverette St		
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of head											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			9:00pm 2-18- 19 69			Shot self with .38 cal. revolver.					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No			City or Town County State		
			Parked car			6040 Fort Foot Road, Prince George County, Maryland					
22a. I certify that I took charge of the remains described above; held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MED CAL EXAMINER <input type="checkbox"/>			ASS STANT MED CAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			2-20-69		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			2-22-69			Cedar Hill Cemetery			Suitland, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Simmons Bros			Wash DC			FEB 24 1969			Charles Judge		
1661-Good Hope Rd SE											

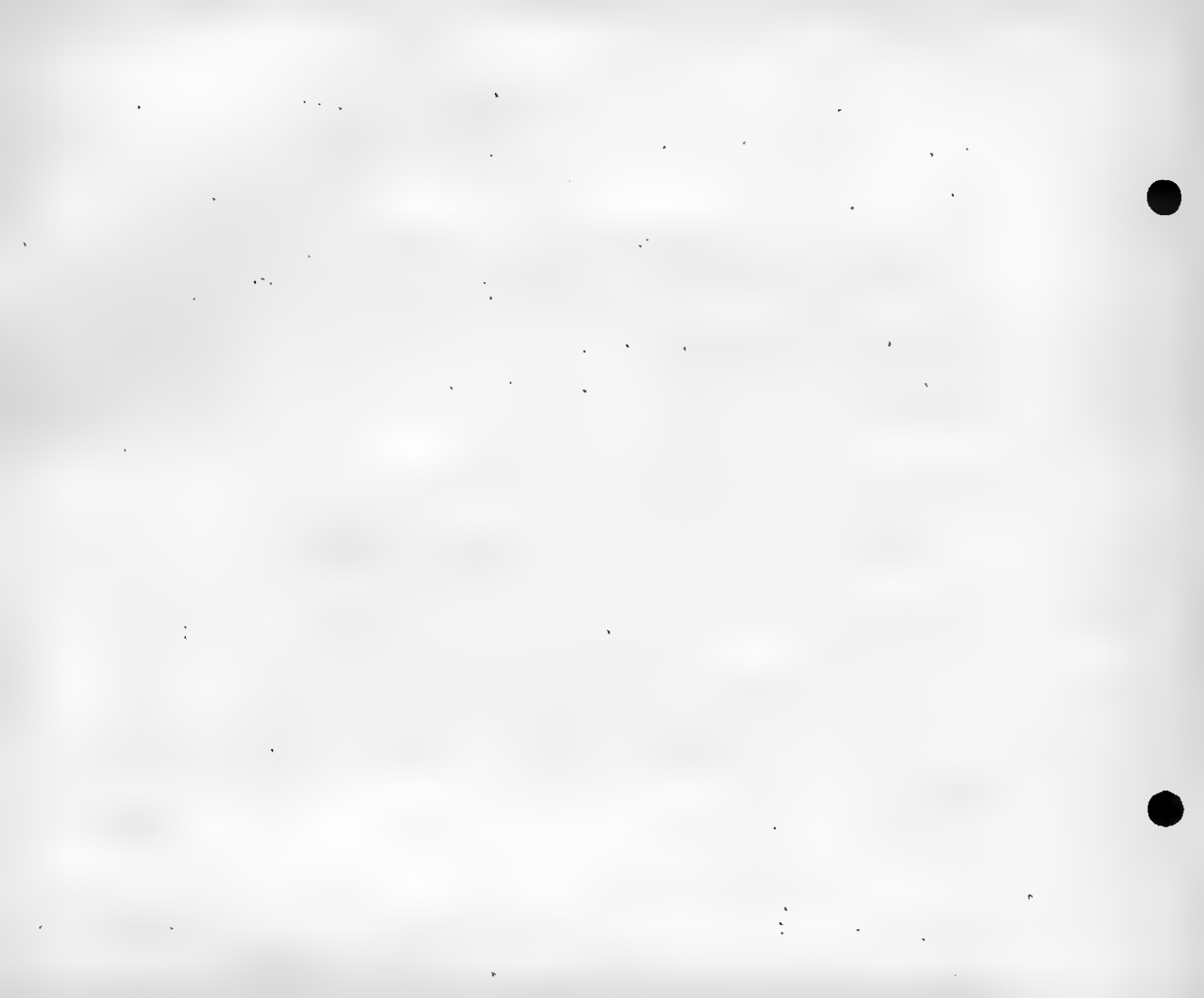


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Lee Eyster Gilbert					Feb Month 5 Day 1969		5 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS
Male		White		Dec 12, 1887		81 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Baltimore Md		USA				Pr. Georges Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work. of life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Laural		421 Montgomery St		Teacher		Pub. School		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md		Pr. Geo.		Laural				421 Montgomery St
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last				
William Edgar Gilbert				Janet Lee English.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No		213-38-1952		Mrs Helen M. Gilbert Laural Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of Prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr 44 hr
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
July 1965		Cancer of Prostate						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1931, to Feb 5, 1969, that (I) (we) last saw the deceased alive on Feb 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Robert S. McCeney						2/5/69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
ROBERT S. MCCENEY, M. D.		402 MAIN ST.						
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		2/5/69		East Laurel Cemetery		Calverton Maryland		
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Canadian Funeral Home Laurel				Feb 5 1969				



FOR STATE
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Items 6&23 Filed 2/25/69		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02786	
1. DECEASED-NAME (Type or Print)		Middle		Last	
George		Goode			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS HOURS MIN
Male	Negro	17 Feb. 1911	55 YRS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Virginia		U.S.A.		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
Cheverly		Prince George Hospital		Not stated	
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Prince George's		Beaver Heights	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Frank Goode		Alice Smith		1516 49th Avenue	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
				Sarah Goode-Wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage 4122 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hypertensive cardio vascular disease (c) over 20 yrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		2-5-69	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2/8/69		Crown	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	
R. Lewis Funeral Home		301 N-12-NE		FEB 14 1969	
				25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02792

02787

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR AM ; 2.08				
Kimberly			Sue Gray			Feb., 9 1969							
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
Female		White		23 Jan., 1969			YRS.		17				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Maryland		U.S.A.					Prince Georges			Md			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly				Pr. Geo., Gen. Hosp.									
13a. U.S.A. RESIDENCE (Where deceased lived if not in hospital admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Pr. Geo.		Tokoma Park		YES		6801 Red Top Rd.			
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME			
Harry								ray		Arlene Kelly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT		Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>486X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) <u>(the doctor)</u> attended the deceased from <u>Jan. 23, 69</u> to <u>Feb. 9, 19 69</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>Feb. 9</u> 19 <u>69</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.													
22b. SIGNATURE <u>John H. Bayly</u>				DEGREE PHYS		ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2-9-69					
22d. PHYSICIAN'S NAME (Type)				John H. Bayly, M.D.		22e. ADDRESS		1835 Eye St., NW., Washington, DC 20006					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
<u>Burial</u>			2-10-1969		Congressional			Washington, D.C.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>R.H. Mattingly</u>				<u>131-11th St. S.E.</u>				DATE FEB 13 1969		<u>Charles Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

02788

1. DECEASED-NAME (Type or print) Lela M. Griffith			2a. DATE OF DEATH Month 2 Day 9 Year 1969			2b. HOUR 6:40 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9-14-1897		6. AGE (In years last birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Revised Sales Lady		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2104 Amberst Road		14. FATHER'S NAME First William Middle L Last Griffith		15. MOTHER'S MAIDEN NAME First Lillian Middle A Last Deneqri			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 577 070811		17. INFORMANT Anton Weidman		Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: 342X IMMEDIATE CAUSE (a) Intestinal Obstruction (Paralytic Ileus) DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis with Parkinson DUE TO, OR AS A CONSEQUENCE OF (c) Dysphagia + secondary anorexia Approximate interval between onset and death 2/7/69 5-10 years aug 1968							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/15/67 , 19 to 2/9/69 , 19, that (I) (we) last saw the deceased alive on 2/9/69 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John J. Sweeney MD				22c. DATE SIGNED 2/9/69			
22d. PHYSICIAN'S NAME (Type) John J. Sweeney				22e. ADDRESS 1905 Gatewood Place			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-13-1969		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or town) Silver Spring (County) MD	
24. FUNERAL DIRECTOR Walley's Funeral Home				ADDRESS 1114 Rainier MD		25a. REC'D BY REG. STRAR FEB 17 1969	
				25b. REGISTRAR'S SIGNATURE [Signature]			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Items 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1, Film 110 3/13/69 jp		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02794		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		02839	
1. DECEASED NAME (Type or Print) <u>Grinder</u> , <u>Richard Marshall</u> ^{First Middle Last}				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI MATED <input type="checkbox"/> Month <u>2</u> Day <u>22</u> Year <u>69</u>		2b. HOUR <u>10:10</u> ^{AM PM}			
3 SEX <u>M</u>	4. RACE <u>W</u>	5. DATE OF BIRTH <u>25 Dec 1901</u>	6 AGE (In years last birthday) <u>67</u> YRS	7 UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	8 UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>	2c. DATE PRONOUNCED DEAD Month <u>2</u> Day <u>22</u> Year <u>68</u>		2d. HOUR <u>10:10</u> ^{AM PM}	
7a. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Prince George</u>		Md.	
10 CITY OR TOWN OF DEATH <u>Riverdale</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Leland Memorial</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY <u>Pattern Mak.</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Virginia</u> COUNTY <u>Fredrick</u>		13c. CITY OR TOWN <u>Winchester</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>Siler Route</u>			
14 FATHER'S NAME First <u>Richard C.</u> Middle <u>Grinder</u> Last <u></u>				15 MOTHER'S MAIDEN NAME First <u>Carrie</u> Middle <u>Elizabeth</u> Last <u>Mowbray</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16b. SOCIAL SECURITY NO <u>216-10-7480</u>		17 INFORMANT <u>Mary E. Grinder</u>		ADDRESS <u>Winchester, Virginia</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u>								<u>Min</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u>								<u>4 yrs.</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <u>19</u> HOUR A.M. <u></u> P.M. <u></u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No <u></u> City or Town <u></u> County <u></u> State <u></u>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <u>John Kenoe, M.D.</u>		EXAMINER'S NAME (Type) <u>Riverdale</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS (Street, city, town, or county) <u></u>		22b. DATE SIGNED <u>2-23-69</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 26, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) <u>Suitland</u> (County) <u>Maryland</u> (State) <u></u>			
24 FUNERAL DIRECTOR <u>Money & King</u>				ADDRESS <u>Vienna, Virginia</u>		25a. REC'D BY REG STRAR <u>Feb 26 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VP A15ME 15
10M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02795 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02789									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Paul Kenneth Gropp						EST. <input type="checkbox"/> MATED <input checked="" type="checkbox"/> 2 8 69		3:00 PM	
3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	7. UNDER 1 YEAR		7. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
M	W	27 May 1919	49 YRS	MONTHS	DAYS	HOURS	MIN	Month 2 Day 8 Year 19 69	2d. HOUR 10:50 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		U. S. A.		Prince George				Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hosp			Maintenance Giant Food Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.			Prince George Rogers Hgts			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
								5504 Farragut St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Charles Gropp			Grace Hayden						
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
Yes			W42			Bertha S. Gropp 2403 57th. Pl. Tuxedo Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									
153X Asphyxia									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) Hanging									Minutes
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			3:00pm 2 8 19 69		Hung self in warehouse				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State				
			Giant Food Warehouse		6900 Sheriff Rd. Prince George Co. Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
John Kehoe			John Kehoe, M.D., Riverdale			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2-9-69	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REINTERMENT			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2-11-69		Resurrection		Clinton Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Robert E. Wilhelm			4308 Suitland Rd. Suitland Md.			DATE FEB 17 1969			



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02790		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH			2b. HOUR
William Waitman Gullett Jr									DATE MATED <input checked="" type="checkbox"/> 2-16-69 19 1			35am
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male	White	12-9-1946	22 YRS	MONTHS		DAYS		Month 2 Day 16 Year 69 19 1			35am M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Missouri		U S A				Prince George's Md						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital									
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before)			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland			Prince George's College Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4313 Knox Road					
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First
William Waitman Gullett Sr									Helen Harmons			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT							
no					William Waitman Gullett sr College Park, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of chest												
955X DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
			1:00am 2-16- 19 69			Shot during altercation						
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or RFD No			City or Town			
			2910 Markham Lane, Hyattsville, Prince George County, Maryland									
22a. I certify that, I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
John Kehoe MD			Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-17-69			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, c.t.y., town, or county)			
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			Feb 19, 1969		Ft Lincoln Cemetery			Colmar Manor Pro Geo Md.				
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons						Hyattsville, Md.		FEB 21 1969				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02797

02791

1. DECEASED-NAME (Type or print) First Middle Last EARL D HARMAS			2a. DATE OF DEATH Month Day Year FEB 13 69		2b. HOUR A.M. 12:50
3 SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH 16 Jun 23		6. AGE (in years last birthday) 45 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) Indiana	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES	
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAFHOSP		12a. USUAL OCCUPATION (Kind of work done during part of working life, even if retired.) FLT STEWART	
12b. KIND OF BUSINESS OR INDUSTRY USAF					
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE FLORIDE		13b. CITY OR TOWN MANATEE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13d. STREET AND NUMBER 130 60th St West					
14. FATHER'S NAME First Middle Last EARL DESMOND HARMAS SR		15. MOTHER'S MAIDEN NAME First Middle Last DENA MARIE CUMMINGS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO 317126388		17. INFORMANT Address (Wife) Same as item #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 42% 2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from <u>9 Feb</u> , 19 <u>69</u> , to <u>13 Feb</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>13 Feb</u> , 19 <u>69</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael P. Stern		DEGREE MC		22c. DATE SIGNED 13 Feb 69	
22d. PHYSICIAN'S NAME (Typed) MICHAEL P. STERN, CAPT USAF		22e. ADDRESS MALCOLM GROW USAFHOSP ANDREWS AFB			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-17-69		23c. NAME OF CEMETERY OR CREMATORY Bradenton Cemetery, Bradenton, Florida	
23d. LOCATION (City or Town) (County) (State) Bradenton, Florida					
24. FUNERAL DIRECTOR W. W. Chambers		ADDRESS 517-11 E. H. A. E.		25a. REC'D BY REGISTRAR FEB 20 1969	
25b. REC'D BY REGISTRAR 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in every event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR P 10:55 M	
Howard Harrison Jr.									2/3/69				
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
M		W		Jan 26, 1902				67 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md			USA					Prince George's Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Chenery				Prince Geo Hospital				plant supervisor				Telephone Co	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER					
Md			Pr Geo			Laurel		507 5th St Laurel Md					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
Howard F. Harrison				Clara Lewis									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO				17. INFORMANT Address					
no				212-10-0346				Willa Harrison - Home					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY													
IMMEDIATE CAUSE (a) Cerebral embolism													
41 - and DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) congestive heart failure													
DUE TO, OR AS A CONSEQUENCE OF													
(c) arteriosclerotic heart disease													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
bronchopneumonia													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1961, to Feb 3, 1969, that (I) (we) lost saw the deceased alive on Feb 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				Dr. Don B. Cameron DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Feb 4, 1969			
22d. PHYSICIAN'S NAME (Type)				3503 Perry Street, Mt. Rainier, Maryland				22e. ADDRESS					
23a. BURIAL, CREMATION, or REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				2-6-69		Inglis Hill Cemetery				Laurel P.G. Md.			
24. FUNERAL DIRECTOR				ADDRESS				25a. RECTORY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Donaldson Jett				Laurel Md				FEB 10 1969		Laurel Judge			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02799

02793

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1 DECEASED NAME (Type or Print) First Middle Last Sylvester Alfred Harrison Jr			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 2-15-69 19 11:15am		
3 SEX Male	4 RACE Negro	5 DATE OF BIRTH 8-17-1968	6 AGE (In years last birthday) YRS MONTHS DAYS 6 6 15		2c DATE PRONOUNCED DEAD Month Day Year 2 15 69 19 11:15pm
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		9. COUNTY OF DEATH Prince George's	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None	
13a USLA RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b COUNTY Prince George's		13c STREET AND NUMBER 7237 79th. Avenue	
14. FATHER'S NAME First Middle Last Sylvester A. Harrison			15. MOTHER'S MAIDEN NAME First Middle Last Sharon Clay		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Sharon Harrison 7237 79th Ave.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY 775X IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SDII DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 2-16-69	
EXAMINER'S NAME (Type) John Kehoe MD		ADDRESS (Street, city, town, or county) Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/19/69		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial	
24. FUNERAL DIRECTOR R.N. Horton Co.		ADDRESS 1324-U St.N.		23d. LOCATION (City or Town) (County) (State) Landover Md.	
25a. REC'D BY REGISTRAR FEB 20 1969		25b. REGISTRAR'S SIGNATURE R. N. Horton			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02794

02800

7 FOR STATE
HEALTH DEPT.

1 DECEASED-NAME (Type or Print)		First	Middle	Lost	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 2-10-69 19 9:00am		2b HOUR
Cleo Elizabeth Harvey							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year	2a HOUR
Female	Negro	5-18-1917	51 YRS			2 Month 10 Day 69 Year 19 10:42am	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
		U.S.A				Prince George's Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USIA. OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital		Housewife		At Home	
13a USIA. RESIDENCE (Where deceased lived, if institution on Res dence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM IS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Prince George's Cedar Heights				6414 L Street	
14. FATHER'S NAME		First	Middle	Lost	15 MOTHER'S MAIDEN NAME		First Middle Lost
Cleo Hill					Pearl Waters		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS	
No		None		John T. HARVEY		same 125 13 E	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH minutes unknown
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-11-69		
John Kehoe MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
		2-15-69		Harmony		Highland Park Md	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
H.S. Washington & Sons 4925 Deane Ave NE				DATE FEB 19 1969			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Bage 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0280

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02795

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR	
Robert Francis Hawkins					2a. DATE KNOWN OF DEATH		2	23	69	3:00 am	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		
M	W	1-14-69		YRS 1	MONTHS 9		HOURS		Month 2 Day 23 Year 19 69		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH			
Md.		U.S.				Prince George		Riverdale			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Leland Hosp				None							
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.				Prince George College Park		NO <input type="checkbox"/>				4915 Blackfoot Rd.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
John W. Hawkins				Mary Susan Lyons							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				None		J. W. Hawkins		College Park, Md.			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5011											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2, or Part 2, item 18.)					
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John Kenoe, M.D., Riverdale				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2-24-69			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Feb. 26, 1969		Frostburg Mem. Park		Frostburg, Md.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Byron Knight		Cumberland, Md.				MAR 3 1969					



02802

CERTIFICATE OF DEATH

02796

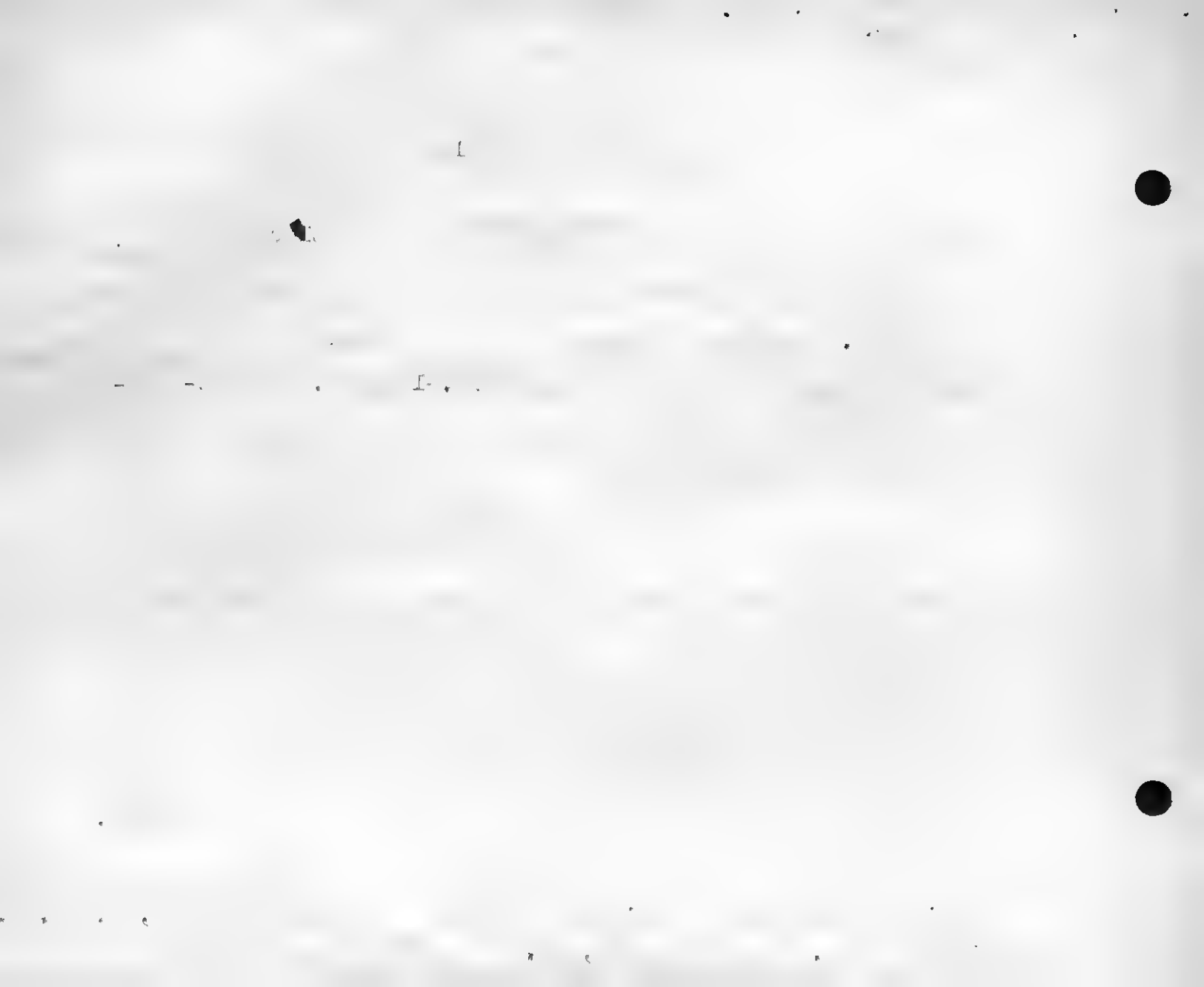
1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR P M	
Svend				Helfer	2/13/69		8:40 P	
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (in years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS	
White	Male	06/28/95			73 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Denmark		U S A				Prince George's County Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly		Hospital						
13a USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		Prince George's		Bowie				3305 Moreland Place
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle Last
Albert			Helfer		Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
no		217 34 1670		Mildred K Helfer		Bowie, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Severe Aspiration Pneumonia and Broncho-Pneumonia</u>								
DUE TO OR AS A CONSEQUENCE OF								
(b) <u>Status Post Resection Abdominal Aorta</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION		Street or R.F.D. No		City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <u>1-17, 1968</u> , to <u>2-13, 1968</u> , that (I) (we) lost saw the deceased alive on <u>2-13, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b SIGNATURE		22c DATE SIGNED						
<i>Wm A Holbrook</i>								
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS						
William A. Holbrook, M.D.		4500 College Park, Maryland		20740				
23a BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		2/17/69		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR		F. Gasch's Sons		Hyattsville, Md.		25a REC'D BY REGISTRAR DATE FEB 19 1969		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Thomas			Ransel	Henault		2 Month 23 Day 69 Year			5:55 PM
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		F UNDER 1 YEAR MONTHS DAYS	
M.		W.		7-10-83		85 YRS.			
7a BIRTHPLACE (State or foreign country)		7b. CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Md.		U.S.A.				Prince George			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR PLACE OF DEATH (If given street address)		12a USUAL OCCUPATION (Kind of work done during most of work life when it retired)		12b KIND OF BUSINESS OR INDUSTRY		Md.	
Clinton		Nursing Home Pineview Gardens		Government		Police Court			
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
Md.		Charles		Beyans Rd.		10 Adelphi Lane			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S M A DEN NAME			First Middle Last
Geo. Matthews Henault						Annie Brooks			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17. INFORMANT		Address		Same as Items 13e-13c:	
Yes		WWI		229-26-625A Mrs. Gladys M. Henault-					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>								2 months	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiovascular collapse</u>								5 minutes	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic disease</u>								3 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/27, 1968</u> to <u>2/23, 1969</u> , that (I) (we) last saw the deceased alive on <u>2/23, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d.d) (d did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Alfred R. Taper		2/23/69		ALFRED R. TAPER, M.D.					
22e. ADDRESS		22f. ADDRESS		CLINTON, MD					
23a B. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		Upper Marlboro, Pr. Geo. Md.	
Burial		2/26/69		Trinity Cemetery					
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Ritchie Bros. Upper Marlboro, Md.				MAR 3 1969		J. Charles Jones			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
Viola Mary Henry						2-11-69		19	10	15pm	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 YEARS		8 DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR
Female	Negro	10-24-1910	58 YRS			2		11	69	19	10:38pm
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
Glen Dale, Md.					WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's		Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Maid					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland			Prince George's			Vista		YES <input type="checkbox"/> NO <input type="checkbox"/>		9817 Annapolis Road	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Howard Edward Matthews						Henrietta Snowden					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
						Bernard E. Henry-husband=			same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure										minutes	
DUE TO, OR AS A CONSEQUENCE OF Hypertensive cardio vascular disease										years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASS STANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.									2-13-69		
23a BURIAL CREMATION REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial			2/15/69		Harmony Memorial Park		Maryland				
24 FUNERAL DIRECTOR						25a RECEIVED BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Stewart Funeral Home-4001 Benning Road						FEB 16 1969					

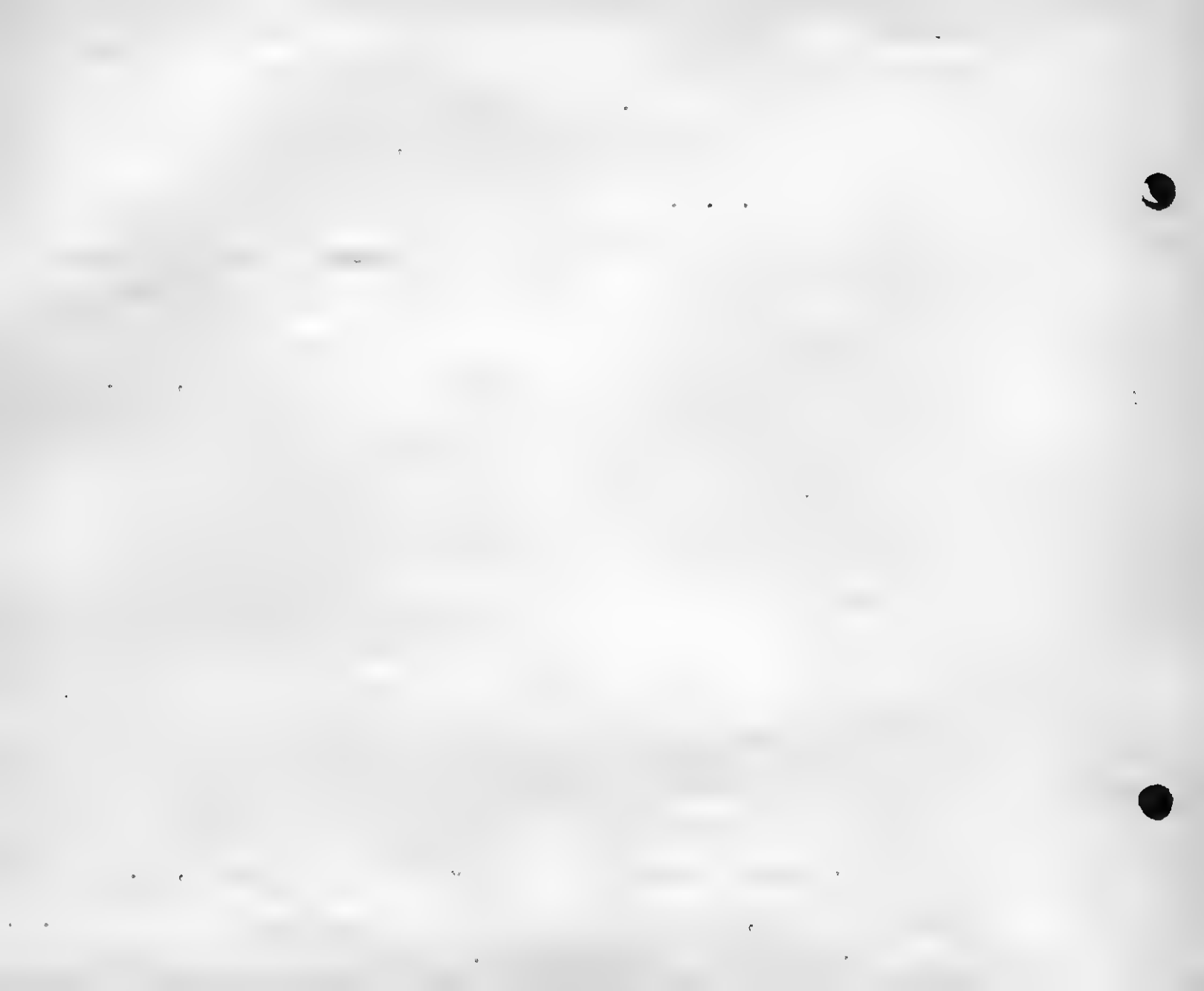


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VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
02805									
02799									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Harold			E. Hill			Month Day Year Feb 12, 1969			205 P M
3 SEX		4. RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
male		white		Jan 20, 1905			64 YRS.		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		U. S. A.				Prince George's Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Riverdale			Leland Hospital			Wholesales Stores		Salesman	
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INS DE CITY LAM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Md			Pro Geo		Adelphi		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8604 Riggs Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Robert Hill			Charlotte I Lepper						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
no					Isabell Hill Adelphi, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 411 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) (OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that (I) (the hospital) attended the deceased from 1956, 19, to Feb 12, 1969, that (I) (we) last saw the deceased alive on Jan 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Dr. Robert C Wingfield					22c DATE SIGNED Feb 13, 1969				
22d PHYSICIAN'S NAME (Type)					22e ADDRESS				
Dr. Robert C Wingfield					329 Pro Geo St Laurel, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Feb 15, 1969		Vale Cemetery		Schenectady		N. Y.	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
F. Gasch's Sons		Hyattsville, Md.		DATE FEB 17 1969					



A15 (4)
30M REV. 1/68

02806		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02806					
Item 3 Film 3110 3/5/69 kk								CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)				First Middle Last		2a. DATE OF DEATH			2b. HOUR		
Mary W. Higgins						Month Day Year 2/24/69			8:45 AM		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Female		Caucasian		10/25/1913			55 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Penna.		U.S.A.				Prince Georges					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Forestville, Md.		Regent Nursing Home		Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Pr. Georges		Forestville		YES <input type="checkbox"/> NO <input type="checkbox"/>		6006 Surrey Sq. Lane			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Charles Wasilka				Katherine Wozniak							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT			Address		
no						Oliver Wesley, Brother			80 Crest Rd., W. Merrit, New York		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ca of Rt Breast - wide											
171											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b) Spread metastases											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-30, 1969, to 2-24, 1969, that (I) (we) lost saw the deceased alive on 2-24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				22c. DATE SIGNED							
Victor L. Humphreys				2-24, 1969							
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
2-27-69		COLD SPRING HARBOUR		LONG ISLAND N.Y.							
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
ROBERT E. WILHELM				SUITLAND, MD		FEB 27 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02807									
02807									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Catherine			L			Hodge			4:30 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		4-9-1884		84 YRS.		MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH
VA.			U.S.A.			PR. George			Md.
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Clinton			Pineview Garden			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?
Md.			PR. George			Suitland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
-			Lindsay			Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (or unknown)			225-14-2515			Janie E. Stowers 4633 Brookfield Dr Suitland Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u>									5 min.
DUE TO OR AS A CONSEQUENCE OF (b) <u>Coronary Insufficiency</u>									3 mrs.
DUE TO OR AS A CONSEQUENCE OF (c) <u>Coronary Arteriosclerosis</u>									5-10 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Old left hip fracture due to circulatory peripheral impairment</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-3, 1968</u> to <u>2-2, 1968</u> , that (I) (we) last saw the deceased alive on <u>2-2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Alfred R. Lapin MD</u>						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, MD</u>						22e. ADDRESS <u>CLINTON, MD</u>			
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2/5/69		Woodland Cemetery		Millboro Virginia		
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u>						25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
4308 Suitland Road Suitland Maryland						FEB 5 1969			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

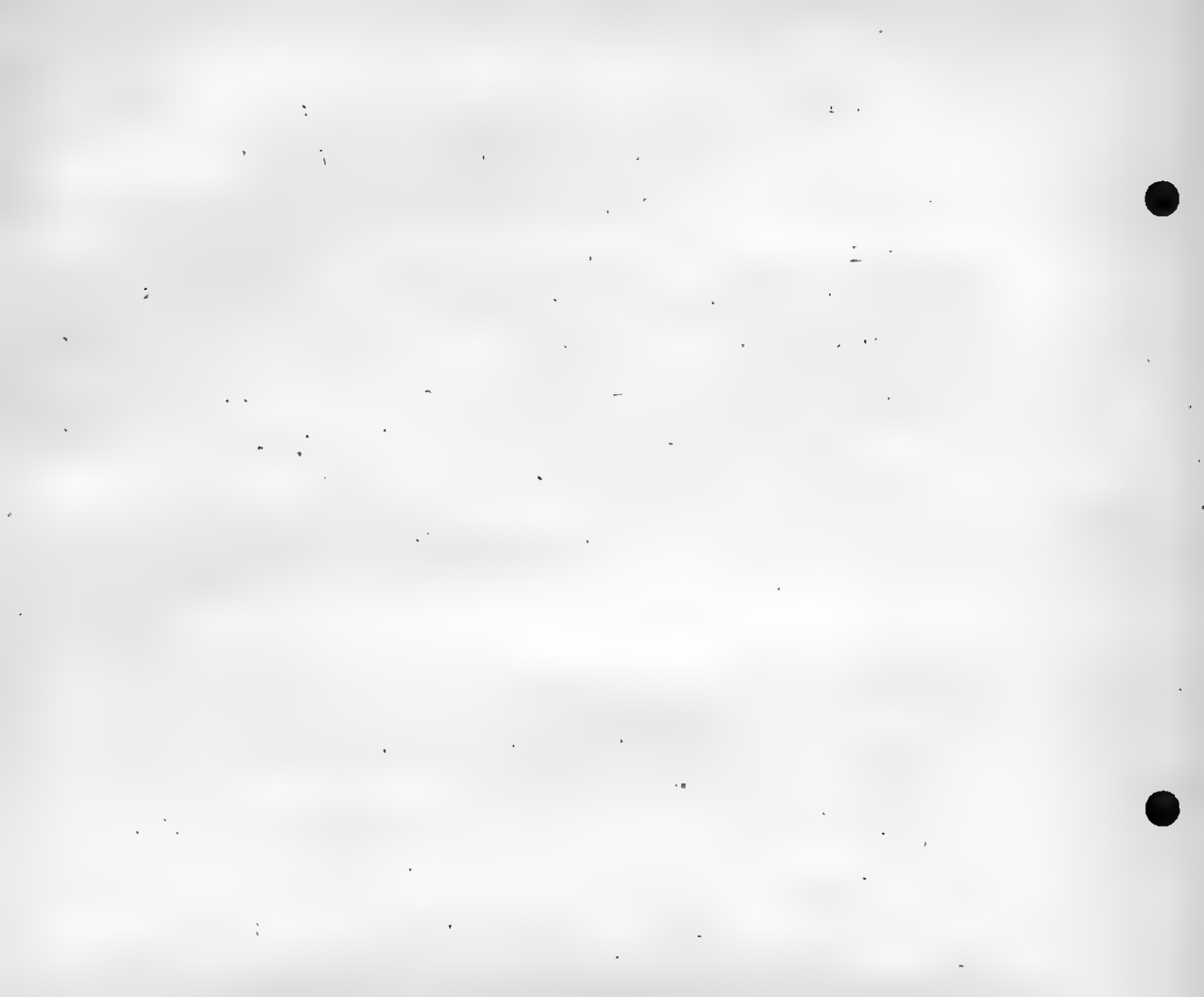
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Grace			Hundsrucker			2 Month 12 Day 69 Year		2:30p M		
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
female		white		12-6-84		84 YRS				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Germany		USA				Prince George Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale			Eugene Leland Memorial			HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George		Bladensburg 20710		YES		5010 Upshur St.,	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Frank Schimpfhauser			UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17 INFORMANT					
NO			NONE		Ethel Haker (daughter) and Medical Records Address SAME AS #13					
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Generalized arteriosclerosis										
4407 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Senility										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 4/5, 19 69, to 4/10, 19 69, that (I) (we) lost soul the deceased alive on 4/12, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)					
Vernon Albertsen, M.D.		4/12/69			Vernon Albertsen, M.D.					
					22e. ADDRESS					
					4408 Queensbury Rd., Riverdale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		2-15-1969		MOORESVILLE CEM		NEFF MILLS, PENNA.				
24. FUNERAL DIRECTOR		ADDRESS			25a. RECEIVED BY		25b. REGISTERED			
W.H. CHAMBERS CO. RIVERDALE, MD.					FEB 20 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02809											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
Miriam			C		Hurd		February 7		1969		
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		2b. HOUR p		
Female		White		October 11, 1879			89 YRS.		1:35 M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
District of Columbia		United States				Prince George Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hyattsville			Sacred Heart Home			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
District of Columbia			Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1012 Monroe Street, N.E.				
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
Albert B. Scrivener			Rebecca Robinson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address						
No			578-62-8288		Sacred Heart Home, Hyattsville, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Acute congestive heart failure and pulmonary edema</i>										4-5 hours	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) <i>Arteriosclerotic and Rheumatic Heart Disease</i>										4 weeks	
DUE TO, OR AS A CONSEQUENCE OF											
last, (c) <i>Arteriosclerosis, general</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<i>Viral infections</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 9, 1968</i> to <i>Feb 7, 1969</i> , that (I) <i>(was)</i> last saw the deceased alive on <i>Feb 7, 1969</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(was)</i> (did) <i>(did not)</i> view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<i>John F. Brennan Jr.</i>								<i>Feb 7, 1969</i>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
<i>JOHN F. BRENNAN JR.</i>		<i>1034 PERRY ST. N.E.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Feb. 11, 1969		Glenwood Cemetery		Washington, D. C.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
<i>Francis J. Collins</i>		DATE <i>FEB 11 1969</i>		<i>Charles Judge</i>							



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 138. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-22a Film 410 MARYLAND STATE DEPARTMENT OF HEALTH
3-10-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02810

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02802

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH				Month	Day	Year	2b. HOUR				
Mildred Margaret Jacobs						ESTIMATED <input checked="" type="checkbox"/> MATED <input type="checkbox"/>				2	21	169	11:00 PM				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				Month	Day	Year	2d. HOUR		
F	W	18 Nov. 1916	52 YRS.	MONTHS	DAYS	HOURS	MIN	2				22	19	68	2:20 AM		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.						
Penna			USA		Prince George												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY						
Cheverley			Prine Geo. General Clerk Typist				US Govt.										
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				138				
Md			Prince George		Silver Hill		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2000 Branch Ave., Apt 13								
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last						
John Myers						Anna Yenklin											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		3000 Branch Ave., Apt 13										
No			209-10-2928		John A Jacobs		Silver Hill, Md										
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intoxication combined ethyl alcohol and Barbiturates																	
1509 DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
MEDICAL CERTIFICATION																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
10 PM 2-21-1969				Ingested overdose of ethyl alcohol and barbiturates													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No				City or Town		County		State	
				Home				Silver Hill				Prince Geo.		Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		John Kehoe, M.D., Riverdale				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)														2-23-69			
ADDRESS (Street, city, town, or county)																	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County)		(State)			
Burial				2-26-69		St. Benedicts Cemetery				Carroltown				Pa			
24. FUNERAL DIRECTOR																	
Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md																	
25a. REC'D BY REGISTRAR																	
DATE FEB 25 1969																	
25b. REGISTRAR'S SIGNATURE																	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02811										02803																								
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										MEDICAL EXAMINER'S CERTIFICATE OF DEATH																								
1 DECEASED-NAME (Type or Print)					First Middle Last					2a DATE KNOWN OF DEATH					2b HOUR																			
Charles Albert James										12-16-69					1948 24 PM																			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD					2d HOUR																	
Male		Negro		1-17-1942		27 YRS		MONTHS DAYS		HOURS MIN		2 Month 16 Day 69 Year 1952 22 PM					M																	
7a BIRTHPLACE (State or foreign country)					7b CITIZEN OF WHAT COUNTRY?					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH					Md.														
Washington, D.C.					USA										Prince George's																			
10 CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)					12a USJA, OCCUPATION (Kind of work done during most of work week even if retired)					12b KIND OF BUSINESS OR INDUSTRY																			
Cheverly					Prince George Hospital					Driver-Florist					Florist																			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before death)					13b CITY OR TOWN					13c INSIDE CITY LIMITS?					13e STREET AND NUMBER																			
Maryland					Prince George's Mitchellville					YES <input type="checkbox"/> NO <input type="checkbox"/>					Box 125B, Rt. 197																			
14 FATHER'S NAME					First Middle Last					15 MOTHER'S MAIDEN NAME					First Middle Last																			
Richard Charles James										Mary Fletcher																								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b SOCIAL SECURITY NO					17. INFORMANT					ADDRESS																			
					217-38-1509					Mary Ann James wife					3806 S. Crane Hwy.																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain															minutes																			
DUE TO, OR AS A CONSEQUENCE OF Trauma - auto accident																																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																																		
(b) DUE TO, OR AS A CONSEQUENCE OF																																		
(c)																																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																		
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY?														
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b TIME OF INJURY Month, Day, Year HOUR A.M.										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
										4:20 PM 2-16- 19 69										Driver of car involved in collision														
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)										21f LOCATION Street or R.F.D. No City or Town County State														
										Rt. 301, 450 ft. north of Mitchellville Rd., Prince George Co., Md.																								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																		
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b DATE SIGNED														
EXAMINER'S NAME (Type)										ASS STANT MEDICAL EXAMINER <input type="checkbox"/>										2-17-69														
John Kehoe MD Riverdale, Md.										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																								
										ADDRESS (Street, city, town or county)																								
23a BURIAL, CREMATION, REMOVAL (Specify)										23b DATE										23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town) (County) (State)				
Burial										2/22/69										Harmony Memorial Park										Landover, Md.				
Frazier's Funeral Home, Inc.																																		
389 R. I. Ave., N. W. D. C.																																		
25a. RECORD BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																								
DATE										FEB 21 1969																								

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02812

02805

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
James Franklin Jarred Jr.						DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 2 Day 16 Year 1969			2b. HOUR 1:00 M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
M	W	10/14/1937	31 YRS	MONTHS	DAYS	HOURS	MIN.	Month 2 Day 16 Year 1969			3:35 a M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Michigan		USA				Prince George					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hosp			Beautician					
13a. U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER		
Md			Prince George			Hyattsville			2910 Markham Lane		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
James F. Jarred, Sr.			Virginia Smithson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
yes						Sandra L. Jarred			7501 Keystone Lane, Forestville, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											Min.
IMMEDIATE CAUSE (a) _____											
DUE TO, OR AS A CONSEQUENCE OF _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF _____											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
			1:00am 2 16 69			Shot during altercation					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		
			Home			Same as #13			County		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held on			Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
Actual Signature			John Kehoe, M.D., Riverdale			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			2-16-69		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL, (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County) (State)	
Burial			2/19/69		Ft. Lincoln Cemetery			Washington, D. C.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Robert E. Wilhelm Funeral Home			DATE FEB 20 1969			J. Charles Judge					
4308 Suitland Rd., S. E., Suitland, Md. 20023											

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3-200-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										02807		
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02813		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH			
Janey			E		Jenkins					2b. HOUR		
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 24 HRS		8. MARRIED	
F			Negro		14 Oct 1893		75 YRS		IF UNDER 24 HRS		NEVER MARRIED	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH			
Maryland			USA			WIDOWED			Prince George			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince George Hosp			Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
Md			Prince George			Jefferson Heights			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
									13e. STREET AND NUMBER			
									1005 66th Ave.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
Benjamin Hawkins			Henrietta Holliday									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
						Mrs. Shirley Chisholm-daughter						
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Heart failure		Minutes
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b)										Arteriosclerotic heart disease		Unknown
STORING THE UNDERLYING CAUSE (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
				HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED				
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				2-9-69				
John Kehoe, M.D., Riverdale				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				
Burial				2/12/69				Harmony Memorial Park				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
Stewart Funeral Home-4001 Benning Road, W.E.				FEB 13 1969				Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02814 Item 23 Film G409 2/18/69 kk CERTIFICATE OF DEATH 02808									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b. HOUR
Matilda			Jenkins			2 5 69			10:35p M
3. SEX		4. RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Female		Negro		6/27/97		71 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
S. Carolina		USA				Prince George Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Glenn Dale, Md.		Glenn Dale Hospital		Unknown-Retired		---			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Wash. D. C.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4508 15th Street, N. W.			
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Unknown			Unknown						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT Address					
Unknown		Unknown		D. C. General Hospital Records					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>								5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recurrent cerebrovascular accident</u>								1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus; hypertensive cardiovascular disease; bilateral amputation</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from <u>9/9/</u> 19 <u>66</u> , to <u>2/5/</u> 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>2/5/</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>Moe Weiss</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>2/5/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Moe Weiss, M.D.</u>				22e. ADDRESS <u>Glenn Dale Hospital, Glenn Dale, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/10/1969		Harmony Memorial Park		Landover Pr. Geo. Md.			
24. FUNERAL DIRECTOR <u>Johnson, F.H.</u>				ADDRESS <u>4804 Georgia Ave. N.W.</u>		24a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Johnston, Judge</u>	
						DATE <u>FEB 11 1969</u>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only one copy, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b HOUR	
JARL		A		JOHANSEN				2 Month 3 Day 69 Year		5:0p M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR		7 UNDER 24 HRS.	
MALE		White		Oct 29, 1879		89 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Norway		U S A				Prince George's Md					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Forestville, Md		Regent Nursing Home		Sheet metal worker		construction					
13a USUAL RESIDENCE (Where deceased lived, if not tut. on. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md		Pro George		E Riverdale				5910 60th avenue			
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
				?						?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address					
no				Olga Johansen		E. Riverdale, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION											
4123 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) CORONARY ATHEROSCLEROSIS											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
OLD (L) CEREBRAL INFARCTION WITH (R) HEMIPARESIS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11 - 10 - 19 69, to 2 - 3 - 19 69, that (I) (we) lost saw the deceased alive on 1 - 28 - 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		22c. DATE SIGNED									
Oliver B. Bond MD		2.3.69									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
OLIVER B. BOND MD		1420 MARLBORO PIKE FORESTVILLE, MARYLAND 20028									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Feb 7, 1969		Washington National		Suitland Pro George's Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
		F. Gasch's Sons Hyattsville Md.		DATE FEB 7 1969							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Mary			First Middle Last M. Johnson			2a. DATE OF DEATH Month Day Year Feb. 21 1969			2b. HOUR 2:25PM		
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH 2/25/1894			6. AGE (In years last birthday) 74 YRS		
7a. BIRTHPLACE (State or foreign country) S. C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince Georges Md.		
10. CITY OR TOWN OF DEATH Glenn Dale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) unknown			12b. KIND OF BUSINESS OR INDUSTRY unknown		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE STATE			13b. COUNTY Wash., D.C.			13c. CITY OR TOWN Wash., D.C.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 18 E St., S. E.			14. FATHER'S NAME First Middle Last unknown			15. MOTHER'S MAIDEN NAME First Middle Last unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no?			16b. SOCIAL SECURITY NO 213 56 3139			17. INFORMANT Josephine Thomas			Address 18 E St., S. E.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia days 47-7 DUE TO, OR AS A CONSEQUENCE OF (b) Acute fulminating pyelonephritis days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis with left cerebro-vascular accident years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic cholecystitis and cholelithiasis; decubitus ulcers											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (this hospital) attended the deceased from 1/26/1969 to 2/21/1969 , that (we) last saw the deceased alive on 2/21/1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) not view the body after death.											
22b. SIGNATURE Moe Weiss						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 2/21/69		
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.						22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 2/28/69			23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park			23d. LOCATION (City or Town) (County) (State) Highland Park, Maryland		
24. FUNERAL DIRECTOR [Signature]						ADDRESS 414 15th. St. S. E.			25a. REC'D BY REGISTRAR DATE FEB 28 1969		
									25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) STIVIA			First Middle Last JOHNSON			2a. DATE OF DEATH Month Day Year 2 23 69			2b. HOUR 2:58 A
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 5-13-34		6. AGE (in years last birthday) 34 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Prince George's		13c. CITY OR TOWN Chapel Oak		13d. INSIDE CITY - MISSES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1210 57th Ave.	
14. FATHER'S NAME First Middle Last FRED			15. MOTHER'S MAIDEN NAME First Middle Last Emily Spriggs			Address Chapel Oak Ave			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no or unknown) <input checked="" type="radio"/> (If yes give war or dates of service) None		16b. SOCIAL SECURITY NO. None		17. INFORMANT Robert Johnson		Address 1210-57th Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiopulmonary collapse 2 deg. DUE TO, OR AS A CONSEQUENCE OF (c) Lupus erythematosus 6 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 2/10, 1967 to 2/23, 1969 , that (I) (we) last saw the deceased alive on 2/23, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Alfred R. Lapien				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-23-1969			
22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, MD				22e. ADDRESS CLINTON, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-26-69		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem Park		23d. LOCATION (City or Town) (County) (State) Nightland Park, Md.			
24. FUNERAL DIRECTOR H.S. Washington				ADDRESS 4925 Deane Ave		25a. REC'D BY REGISTRAR EFF 27 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02818

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02812

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR A	
Dora		Caroline		Johnston	February 15, 1969		12:59	
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	White		6/12/04		64 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Pa		U S A				Prince George's Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George's Gen. Hosp.		Housewife		Home		
13a USUAL RESIDENCE (Where deceased admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		Prince George's		College Park				8503 Potomac Ave.
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last					
Roll Crissman			Ann Johns					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
no				Alex Johnston		Ford City, Pa.		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from Feb. 10, 1969, to Feb. 15, 1969, that (I) (we) last saw the deceased alive on Feb. 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		22c DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
Hernandez, M.D.		2/15/69		Tomas J. Hernandez, M. D.				
22e ADDRESS		22f. PHYSICIAN'S NAME (Type)						
Cheverly, Md.		Prince George's General Hospital						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		Feb 18, 1969		Ford City Cemetery		Ford City Armstrong		Pa
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
F. Gasch's Sons		Hyattsville, Md.		FEB 19 1969				

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 4-B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02813					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH			2b. HOUR			
Clifton			A		Jones				2-13-69			19 5:00am			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR		
Male		Negro		5-30-1908		60 1/2 YRS		MONTHS DAYS HOURS MIN		Month 2 Day 13 Year 69			19 7:10am		
7a. BIRTHPLACE (State or foreign country)			7b. C. T. ZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				Md		
Miss.			U.S.A.						Prince George's						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince George Hospital				Laborer				Construction			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland				Prince George's Glen Arden						YES <input type="checkbox"/> NO <input type="checkbox"/>		1430 7th. Street			
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First Middle Last	
Anderson Jones										Minnie Bolling					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT				ADDRESS			
No				None				William Jones				5404 Sheriff Rd NE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Heart failure										minutes					
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										over 4 mo.					
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				HOUR A.M. P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No		City or Town		County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				2-13-69							
John Kehoe MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)							
Riverdale, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County) (State)			
1-18-1968				Harmony Mem Park		Highland Park		Md.							
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
H S Washington & Sons				4925 Deane Ave NE				DATE FEB 19 1969							

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M
Olena			M.		Jones	2 Month 2 Day 1 Year 69			5:30 A
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS M.N.	
Female		White		Sept. 16, 1889		79 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Md.			
So. Carolina		U. S. A.				Prince George			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of last year, or if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Forestville Md.			8466 Donnell Pl.			Housewife		Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Prince Geo.		Forestville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8466 Donnell Pl.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last			
James B. McNeely						May E. Battle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
Yes, no, <u>no</u> (known)					Eva D. Jones 8466 Donnell Pl.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) Candidans, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> , 19 <u>68</u> , to <u>Jan 31</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>Jan 15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John F. Shay</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2-1-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>JOHN F. SHAY</u>					22e. ADDRESS <u>5509 Old Silver Hill Rd, Suitland, Md</u>				
23a. BURIAL, CREMATION, REMOVAL <u>Buried</u>		23b. DATE <u>Feb. 4, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mary Love</u>		23d. LOCATION (City or Town) (County) (State) <u>Hamlet N. C.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Robert E. Wilhelm Funeral Home 4308 Suitland Rd. Suitland</u>					25a. REC'D BY REGISTRAR <u>FEB 5 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William A. Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02821

02815

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Ruth</i> First <i>D.</i> Middle <i>Jones</i> Last			2a. DATE OF DEATH Month <i>Feb.</i> Day <i>25</i> Year <i>1969</i>			2b. HOUR <i>8 PM</i>	
3 SEX <i>Female</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>8-8-1895</i>		6. AGE (In years last birthday) <i>73</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George</i> Md.	
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Pineview Gardens</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE <i>md</i>		13b. COUNTY <i>P.O.</i>		13c. CITY OR TOWN <i>over Hill</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <i>Jed</i> First <i>Willet</i> Middle Last		15. MOTHER'S MAIDEN NAME <i>UNKNOWN</i> First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO.		17 INFORMANT <i>James A. Taylor - 1603 - Oldbury Rd SE</i>		Address <i>Frederick md</i>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Abdominal</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinomatosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>DIABETES MELLITIS</i>							
19a. DATE OF OPERATION <i>Oct 1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>MASS IV INGUINUM</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NOT CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>None</i> Month <i>None</i> Day <i>None</i> Year <i>None</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>None</i>			
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE, BUILDING, ETC.) <i>None</i>		21f. LOCATION Street or R.F.D. No. <i>None</i> City or Town <i>None</i> County <i>None</i> State <i>None</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 5, 1969</i> , to <i>Present</i> , that (I) (we) last saw the deceased alive on <i>Feb 13, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>Arthur Shaver Jr MD</i>		22c. DATE SIGNED <i>2/25/69</i>		22d. PHYSICIAN'S NAME (Type) <i>ARTHUR SHAVER JR MD</i>		22e. ADDRESS <i>880 S BRANCH AVE, CLINTON, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Feb. 27-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Johns Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Broadcreek, Maryland</i>	
24. FUNERAL DIRECTOR <i>Simmons Bros</i>		ADDRESS <i>1661 Good Hope Rd SE</i>		25a. REC'D BY REGISTRAR <i>Feb 26 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

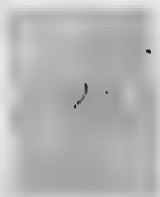
02816

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <u>CAROLINE L. Kelly</u>			2a. DATE OF DEATH Month <u>2</u> Day <u>28</u> Year <u>69</u>			2b. HOUR <u>7:10 PM</u>	
3 SEX <u>FE</u>		4 RACE <u>W.</u>		5 DATE OF BIRTH <u>9/10/76</u>		6 AGE (In years last birthday) <u>92</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>WASH. DC.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince Georges</u> Md	
10 CITY OR TOWN OF DEATH <u>Adelphi, Md.</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>MARION CARE 1801 MONTGOMERY</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Clerk</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	
13a. USUAL RESIDENCE (Where deceased had admission) STATE <u>Md.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Sp.</u>		13d. INS. DE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>331 50. Hampton Ave.</u>		14 FATHER'S NAME First <u>Nicholas</u> Middle <u>Lochbach</u> Last <u>Beckhold</u>		15 MOTHER'S MAIDEN NAME First <u>Caroline</u> Middle <u>Beckhold</u> Last <u>Beckhold</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>88-578 66 8167</u>		17 INFORMANT <u>MARGARET BAKER</u>		Address <u>331 50. Hampton Ave.</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Melanotic carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-16</u> to <u>2-28</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-28</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Morton A. Itschewitz, M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED <u>2-28-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Morton A. Itschewitz, M.D.</u>				22e. ADDRESS <u>9205 New Hampshire Ave. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>March 3, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Bladensburg, Md.</u>	
24. FUNERAL DIRECTOR <u>Francis Hallis</u>		ADDRESS <u>590 University Blvd. N. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 4 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02823

CERTIFICATE OF DEATH

02817

1 DECEASED-NAME (Type or print) Charles Knox		First	Middle	Last	2a DATE OF DEATH 2/12/69 Month Day Year			2b HOUR 5:45 P M	
3. SEX Male		4 RACE White		5. DATE OF BIRTH 11/24/96		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Brooklyn N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md.			
10 CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Generalist - retired		12b KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Laurel		13d INSIDE CITY - YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7401 Brooklyn Bridge Road	
14 FATHER'S NAME John		First	Middle	Last	15. MOTHER'S MAIDEN NAME Mary Matilda Drescher		First	Middle	Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes (If yes give war or dates of service) WWI		16b SOCIAL SECURITY NO 220-38-1830		17 INFORMANT Philip V Knaf Address					
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Extreme Calcific Aortic Stenosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Feb 12, 1969 to Feb 12, 1969 , that (I) (we) last saw the deceased alive on Feb 12, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.									
22b. SIGNATURE Don B. Cameron		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2/13/69			
22d. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D.		22e. ADDRESS 3503 Perry Street, Mt. Rainier, Md. 20822							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 2-15-69		23c NAME OF CEMETERY OR CREMATORY St Mark's Cem		23d LOCATION (City or Town)		(County) (State)	
24 FUNERAL DIRECTOR De Witt Donaldson Laurel, Md		ADDRESS		25a REG BY REG STRA 1969		25b REGISTRAR'S SIGNATURE for the Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for both papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Helen			Middle Koutsos			Last		
2a. DATE OF DEATH			Month 2/4/69			Day 69			Year 1969		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 3-4-1894			6. AGE (In years last birthday) 74 YRS.		
7a. BIRTHPLACE (State or foreign country) GREECE			7b. CITIZEN OF WHAT COUNTRY? GREECE			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's County Md.		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY District of Columbia			13c. CITY OR TOWN Cheverly			13d. STREET AND NUMBER 3112 O Street S.E.		
14. FATHER'S NAME ATHANASIOS			First Middle Last			15. MOTHER'S MAIDEN NAME ROUPAS			First Middle Last UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. NONE			17. INFORMANT MR MIKE J. KOUTSOS			Address Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of the rectum with metastases 1541 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 1/28/69			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Rectum Carcinoma			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/26, 1969, to 2/4, 1969, that (I) (we) last saw the deceased alive on 2/4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Frederick H. Wilhelm M.D.			22c. DATE SIGNED 2/4/69			22d. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm M.D.			22e. ADDRESS 6319 Landover Road, Cheverly, Maryland		
23a. BURIAL, CREMATION, OR OTHER DISPOSAL Burial			23b. DATE 2-7-1969			23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY			23d. LOCATION (City or Town) (County) (State) SOUTLAND MARYLAND.		
24. FUNERAL DIRECTOR W. W. HAMBERS			ADDRESS RIVERDALE, MD			25a. REC'D BY REGISTRAR DATE FEB 10 1969			25b. REGISTRAR'S SIGNATURE		

FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02819

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH EST. <input checked="" type="checkbox"/> Month Day Year MATED <input type="checkbox"/> 2-10-69 1911:45am			2b HOUR		
Margaret D Lane											
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year			2d HOUR		
Female	White	10-6-1899	69 YRS			2 Month 10 Day 69 Year 19 11:45am					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
Delaware		U S A				Prince George's					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Riverdale			Iceland Memorial Hospital			Secretary			U S Gov't		
13a USUA. RESIDENCE (Where deceased lived, if not in institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince George's			Hyattsville			6802 Highview Terrace		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
Daniel Scannell			Mary Creeden								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
no			577 60 3476			Wallace Lane			Hyattsville, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4:00 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture of left hip 1-11-69											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?					
1-14-69			Fracture of left hip			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. PM P.M. 1-11-19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fell at home					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No same as #13			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS STANT MED. CAL. EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			2-11-69		
John Kehoe MD			Riverdale, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Removal			Feb. 11, 1969			7 & Brook St.			Wilmington, Del.		
24. FUNERAL DIRECTOR						25a. RECD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons 4739 Balt. Ave. Hyattsville						DATE FEB 14 1969			[Signature]		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02826

02820

1 DECEASED NAME (Type or print) Milton F. Lathem			2a DATE OF DEATH Month Mar Day 2 Year 69			2b HOUR 10:30 AM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH 11/20/08		6 AGE (In years last birthday) 60 YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md			
10 CITY OR TOWN OF DEATH Glenn Dale Maryland		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Glenn Dale Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Plumber		12b KIND OF BUSINESS OR INDUSTRY --			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE 13b COUNTY		13c CITY OR TOWN Wash., D. C.		3d. INSIDE CITY...M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 615 E Street, N. W.			
14 FATHER'S NAME First Alonzo Middle Lathem Last Lathem			15 MOTHER'S MAIDEN NAME First Bertha Middle Laughlin Last Laughlin						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes		(If yes give war or dates of service) 1940-1942		16b SOCIAL SECURITY NO 298-66-8579		17 INFORMANT Decedent Address			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident (clinical)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis								years	
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis								years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary tuberculosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that the (this hospital) attended the deceased from 9/16/ , 19 68 , to 2/2/ , 19 69 , that he (we) last saw the deceased alive on 2/2 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) not view the body after death.									
22b. SIGNATURE Moe Weiss				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2/2/69			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22e ADDRESS Glenn Dale Hospital, Glenn Dale, Md.					
23a BURIAL, CREMATION REMOVAL (Specify) Removal-Burial		23b DATE 2/6/69		23c NAME OF CEMETERY OR CREMATORY Northern Cemetery		23d LOCATION (City or Town) (County) (State) Smithfield Jefferson Ohio			
24 FUNERAL DIRECTOR Beaverley E. Hopping				25a. REC'D BY REGISTRAR FEB 5 1969		25b. REGISTRAR'S SIGNATURE Charles J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) GEORGE LEACH			2a DATE OF DEATH 2 Month 3 Day 69 Year			2b HOUR 10:40P M			
3 SEX M		4 RACE W		5 DATE OF BIRTH 1/18/99		6 AGE (In years last birthday) 70 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.	
7a BIRTHPLACE (State or foreign country) England		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.			
10 CITY OR TOWN OF DEATH Clinton, Md		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Steamfitter		12b KIND OF BUSINESS OR INDUSTRY Chemical			
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Md		13b COUNTY PG		13c CITY OR TOWN Clinton		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 9602 Beverly Avenue	
14 FATHER'S NAME First Middle Last Thomas James Leach				15 MOTHER'S MAIDEN NAME First Middle Last Charlotte Maria Hutton					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b SOCIAL SECURITY NO. 389-32-9153		17 INFORMANT Daughter Katherine Tomei 9602 Beverly Ave., Clinton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY LI IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) cardiovascular arterial disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 minutes 16 hrs 3 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Alfred R. Lippman				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) ALFRED R LIPPMAN				22e ADDRESS CLINTON, MD					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 2/8/69		23c NAME OF CEMETERY OR CREMATORY St. Henry Cemetery		23d LOCATION (City or town) (County) (State) Watertown, Wisconsin			
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home				4308 Suttland Rd., S.E. ADDRESS		25a. REC'D BY REGISTRAR Feb 11 1969		25b REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02822

02822

1. DECEASED NAME (Type or print) First Middle Last Adelaide G. LeBuffe			2a. DATE OF DEATH Month Day Year February 20 1969			2b. HOUR 7:45 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 29, 1888		6. AGE (in years last birthday) 80 YRS.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.	
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2220 Osborne Drive		14. FATHER'S NAME First Middle Last Bernard F Garvey		15. MOTHER'S MAIDEN NAME First Middle Last Johanna Flinn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 220-48-8596		17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS - C Congestive failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTHYROIDISM</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 MONTHS 3 MONTHS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-6</u> , 19 <u>69</u> , to <u>2-20</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-20</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do not) view the body after death.							
22b. SIGNATURE <u>Thomas F Collins MD</u>				DEGREE MD		22c. DATE SIGNED 2-20 69	
22d. PHYSICIAN'S NAME (Type) THOMAS F COLLINS MD				22e. ADDRESS 2600 Green Chapel Road			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/24/69		23c. NAME OF CEMETERY OR CREMATORY St Johns		23d. LOCATION (City or Town) (County) (State) Forest Glen Md	
24. FUNERAL DIRECTOR W H Tattner				ADDRESS 4748 Wisc Ave NW		25a. REC'D BY REGISTRAR DATE FEB 24 1969	
				25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>			



CERTIFICATE OF DEATH

02829

02823

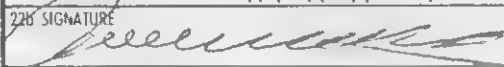
1 DECEASED-NAME (Type or print) William C. Linford			2a. DATE OF DEATH Month Feb. Day 17 , Year 1969			2b. HOUR P 7:15 M				
3 SEX Male		4. RACE White		5 DATE OF BIRTH 11/13/27		6 AGE (In years last birthday) 41 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) N Y		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Nacke Co	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince Georges		13c. CITY OR TOWN Palmer Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7606 Oxmon Road	
14. FATHER'S NAME First Middle Last William Grant Linford			15. MOTHER'S MAIDEN NAME First Middle Last Lorraine Mathias							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) yes			16b. SOCIAL SECURITY NO. 577 34 1562		17 INFORMANT Eleanor Linford			Address Palmer Park, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Intracerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Ruptured Right Ant. Cerebral Artery (b) Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 11/13/69 , 19____, to 2/17/69 19____, that (I) (we) last saw the deceased alive on 2-17 19 69 , and that in (my)(our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (d not) view the body after death.										
22b. SIGNATURE [Signature]			DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 2/18/69				
22d. PHYSICIAN'S NAME (Type) JOHANNES SAPAKIAN			22e. ADDRESS 6001 Landover Rd Cheverly, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Feb 21, 1969		23c. NAME OF CEMETERY OR REPOSITORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24 FUNERAL DIRECTOR F. Gasch's Sons			ADDRESS Hyattsville, Md.			25a. RECEIVED BY REGISTRAR FEB 24 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02830

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last HARRY T. LITZENBERGER			2a. DATE OF DEATH Month Day Year 2 24 69			2b. HOUR 2:10A	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 1-10-95		6. AGE (in years last birthday) 74 YRS.	
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S. CITIZEN		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES	
10. CITY OR TOWN OF DEATH Clinton Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Clinton Community Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. GOVERNMENT INVESTIGATOR		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY U.S.A.		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 4800 T STREET S.E.		14. FATHER'S NAME First Middle Last ALFRED LEVI LITZENBERGER		15. MOTHER'S MAIDEN NAME First Middle Last JOSEPHINE KLAISS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) WORLD WAR II	
16b. SOCIAL SECURITY NO. 578-33-0509		17. INFORMANT MARTHA JANE SPALDING		Address 11612 TYRE ST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL-VASC. ACCIDENT 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Flu with pneumonia, ENOPHTHEMA,							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2/13 , 19 69 , to 2/24 , 19 69 , that (I) (we) last saw the deceased alive on 2/24 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		2/26/69		Cedar Hill Cemetery		Washington, D. C.	
24. FUNERAL DIRECTOR Robert Wilhelm Funeral Home				25a. REC'D BY REGISTRAR FEB 27 1969		25b. REGISTRAR'S SIGNATURE W. Charles Vande	
Address 430 S. Sultland Rd., S.E., Washington, D.C. 20023							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR 115
304 REV

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR A M
Lelia			M		Long	2/8/69			3:30
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (n years lost birthday)		F UNDER 1 YEAR MONTHS DAYS	
Female		White		06/01/17		51 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
D C.		U S A.				Prince George's County Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly			Hospital Prince George's			Clerk			
13a USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c CITY OR TOWN		13e STREET AND NUMBER	
Maryland			Prince Geo.			Seat Pleasant		6402 Greig Street	
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Herbert			Sisson			Susan			Woodville
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
						James M. Long same as 13e			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive encephalopathy and renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe hypertensive cardiovascular disease.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		Street or R.F.D. No		City or Town County State	
22a. I certify that (if this hospital) attended the deceased from <u>June</u> , 19 <u>68</u> , to <u>8 Feb</u> , 19 <u>69</u> , that (if) (we) last saw the deceased alive on <u>Feb 8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE						22c. DATE SIGNED			
<u>Robert D. Deitz</u> - DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Robert D. Deitz, M.D.						Hyattsville, Maryland Prince George's Plaza			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Burial		2.11.69		Cedar Hill Cemetery		Suitland, Maryland			
24. FUNERAL DIRECTOR						25a. REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE	
Lee Funeral Home. 300.4th st N E						DATE FEB 11 1969		<u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO DEPUTY CHIEF EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

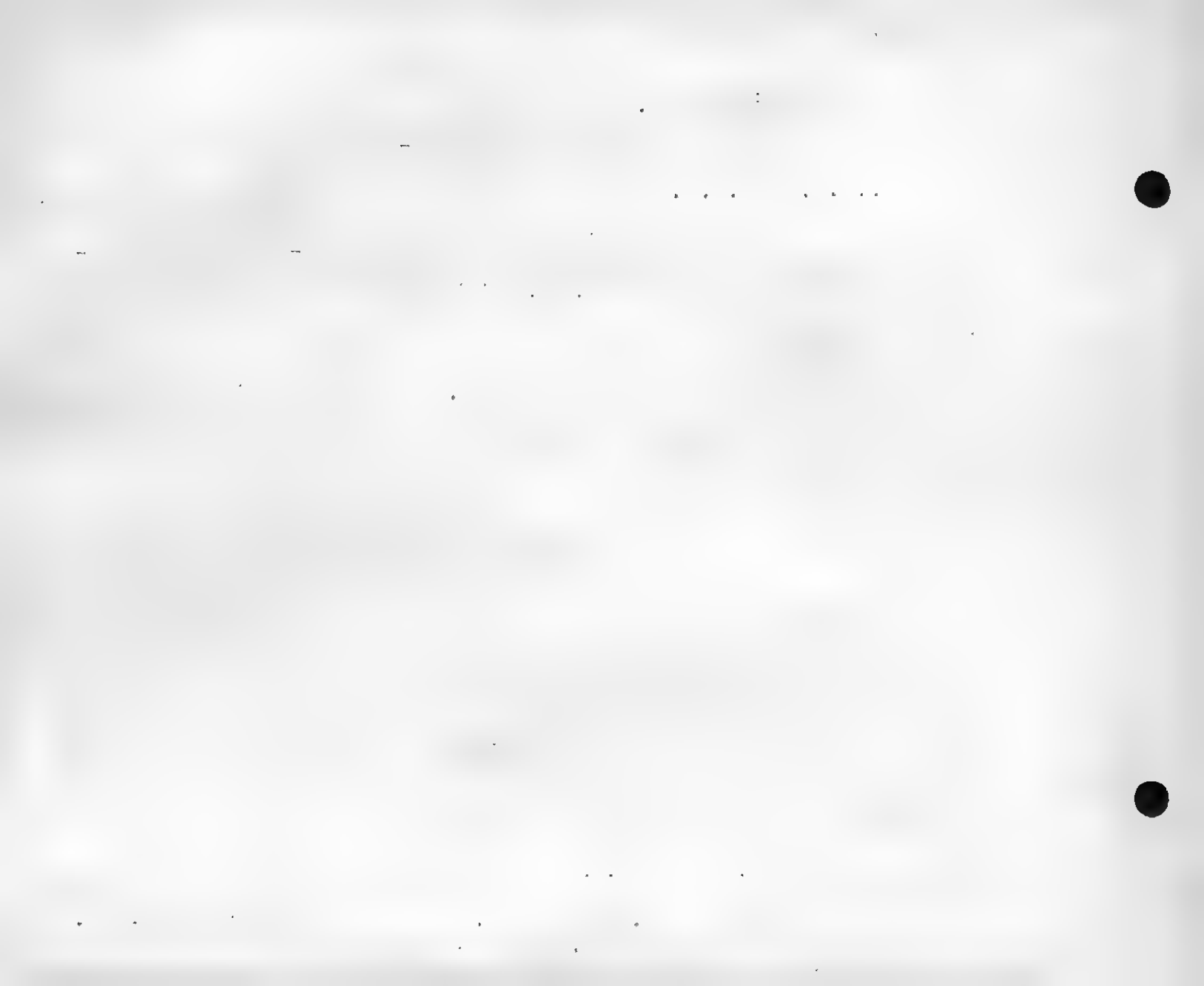
VR A15ME (5)
10M REV 1 68

<div style="display: flex; justify-content: space-between;"> 02832 MARYLAND STATE DEPARTMENT OF HEALTH 02826 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>																	
1. DECEASED NAME (Type or Print)						2a. DATE KNOWN OF DEATH						2b. HOUR					
First		Middle		Last		Month		Day		Year		9:00 a.m.					
John		Thomas		Mangum		2		24		19		69					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD					
M		W		25 Jan 1902		67 YRS		MONTHS		DAYS		HOURS MIN					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		2d. DATE PRONOUNCED DEAD		2e. HOUR					
Wash. D. C.		U.S. A.		WIDOWED		DIVORCED		Prince George		Month 2		Day 24 Year 19 69 10:20 a.m.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly				Prince George				Foreman				Lumber Yard					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY RIM 157		13e. STREET AND NUMBER			
Md				Prince George St. Pleasant				NO				415		70th St.			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
First		Middle		Last		First		Middle		Last							
Horace		Mangum				Rebecca		Burroughs									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT				ADDRESS					
NO								Doris T. Merritt				Chincoteague Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												M.H.					
4123 Heart failure																	
DUE TO, OR AS A CONSEQUENCE OF																	
(b) Arteriosclerotic heart disease												over 5 yrs.					
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
				P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				M.D.				22b. DATE SIGNED									
EXAMINER'S NAME (Type)				John Kehoe, M.D., Riverdale				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				2-27-69				Washington National				Suitland Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Robert E. Wilhelm				4308 Suitland Road Suitland Md.				MAR 4 1969				J. Charles Judge					

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MARTLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
02833										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	
Perry Martin			A.		Martin				2/4/69 Month Day Year	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7b. IF UNDER 1 YEAR MONTHS DAYS	
Male		White		06/29/95 1894			74 YRS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Wash., D.C.			U.S.A.					Cheverly, Prince George's- Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George's Hospital			Retired - Navy Yard				
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY			13c. INS DE CITY, M TS? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Prince Geo. Mt. Rainier					2901 Arundel Rd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Benjamin Martin			Alice Robey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address	
Yes			WWI			220-32-7355			Mrs. Genevieve Martin (above address)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MASSIVE ACUTE INTRA-CEREBRAL</u>										12 HRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) <u>HEMORRHAGE</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>HYPERTENSIVE CEREBRO-VASCULAR DISEASE</u>										2-3 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> ND <input type="checkbox"/>		YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (1) (this hospital) attended the deceased from <u>2-3-69</u> , 19 <u>48</u> to <u>FEB</u> , 19 <u>69</u> , that (1) (we) last saw the deceased alive on <u>2-3-69</u> 19 <u>48</u> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			22c. DATE SIGNED							
<u>Benjamin S. Miller MD</u>			4 FEB 69							
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
Benjamin S. Miller, M.D.			Prince Georges Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		2/7/69		Ft. Lincoln Cem.			Colmar Manor, Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Nalley's Funeral Home Inc.		DATE FEB 10 1969								



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02834

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02828

1. DECEASED NAME (Type or print) Anna V. Massicotte			2a. DATE OF DEATH Month 2 Day 17 Year 1969			2b. HOUR 10:52 PM			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH 11-16-99		6 AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Conn.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.			
10 CITY OR TOWN OF DEATH Forestville, Md		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent 7420 Marlboro Pike		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Md		13b. COUNTY Prince George		13c. CITY OR TOWN District Heights		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3120 W. Wintergreen Ave.	
14. FATHER'S NAME First Michael Middle Stack Last Stack			15. MOTHER'S MAIDEN NAME First Mary Middle Shea Last Shea			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO			17. INFORMANT Francis B. Massicotte			Address 3120 Wintergreen Ave., District Heights, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage 4211 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cerebrovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MO	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cellulitis of legs									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (A) (this hospital) attended the deceased from Feb 13, 1969 , to Feb 18, 1969 , that (B) (we) last saw the deceased alive on Feb 17, 1969 , and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above, (D) (we) (did) (did not) view the body after death									
22b. SIGNATURE W.B. Sheer M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Feb. 18, 1969			
22d. PHYSICIAN'S NAME (Type) WALTER B. SHEER		22e. ADDRESS 6400 MARLBORO PIKE S.E. WASH. D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/20/69		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va.			
24. FUNERAL DIRECTOR Robert F. Wilhelm Funeral Home 4308 Suitland Rd., S. E., Suitland, Md. 20023				25a. REC'D BY REGISTRAR FEB 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) DOVA			First Middle Last McCullough			2a. DATE OF DEATH Month Day Year 2/27/69			2b HOUR 8²⁵ P
3 SEX Female	4 RACE White		5 DATE OF BIRTH 11/7/1880			6 AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Nashville, Tenn		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George			10. M.D. MD
10. CITY OR TOWN OF DEATH Clinton		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Pineview Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) VA adm.			12b. KIND OF BUSINESS OR INDUSTRY WORK		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY NE		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 116 6th Street NE	
14. FATHER'S NAME First Middle Last Jacob R McCullough			15. MOTHER'S MAIDEN NAME First Middle Last Ella Hutsell Tenn.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 578-62-2888		17. INFORMANT Ben Julian		Accokeek, Md. 20607		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardiac collapse									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Coronary circulatory insufficiency									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Arteriosclerotic cardiovascular disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 5-12-67 to 2-27-69 , 19 69 , that (I) (we) last saw the deceased alive on 2-27-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Alfred R. Lapin MD		22c. DATE SIGNED 2/27/69			22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, MD				
22e. ADDRESS CLINTON, MD									
23a. BURIAL, CREMATION, REMOVAL, ETC. BURIAL		23b. DATE March 3, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City or Town) (County) (State) Washington, D.C.			
24. FUNERAL DIRECTOR HUNT FUNERAL HOME		24b. ADDRESS Waldorf, MD			25a. REGISTRY REGISTRAR MAR 3 1969		25b. REGISTRAR'S SIGNATURE Charles Jones		

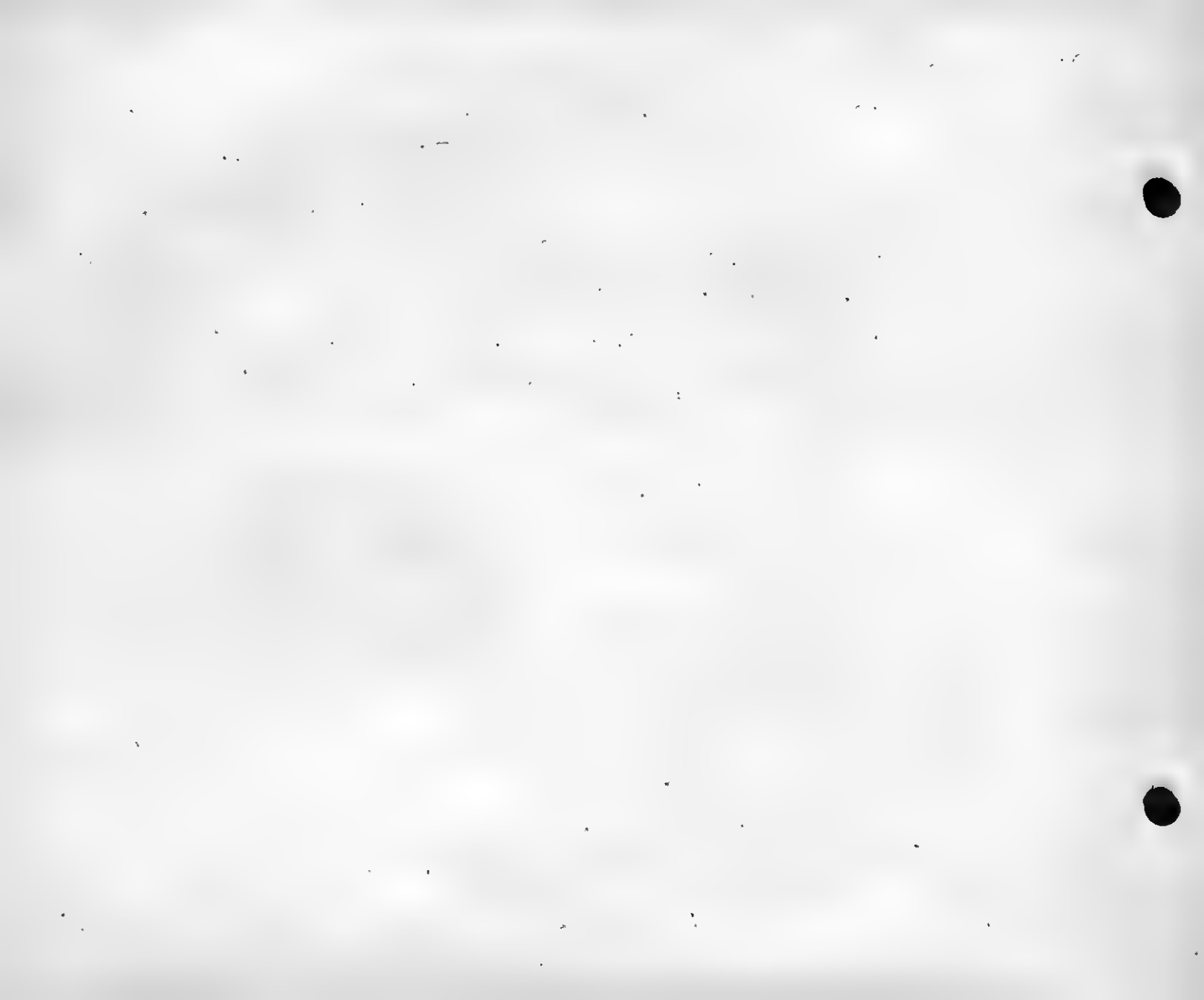
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02536

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Booker		Middle KENNEDY		Last McLean		2a DATE OF DEATH Month 2 Day 7 Year 69		2b HOUR 2:20 M M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 1-13-89		6 AGE (In years lost birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) TENN.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES New Carrollton, Md.			
10 CITY OR TOWN OF DEATH CHEVERLY		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PRINCE GEORGE'S GEN HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ELECTRICAL ENGINEER		12b KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT			
3a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b COUNTY PRINCE GEORGE'S		13c CITY OR TOWN NEW CARROLLTON		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 5401 85th Avenue	
14. FATHER'S NAME First JOHN Middle McLEAN Last McLEAN		15. MOTHER'S MAIDEN NAME First DORA Middle McMILLAN Last McMILLAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES W.W.I.		16b. SOCIAL SECURITY NO 410 286862		17. INFORMANT MRS ALLEAN E. McLEAN Address Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4102 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/20/66 , to 2-7-69 , that (I) (we) last saw the deceased alive on 1-9-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Agustin V. H. Laurin M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-7-69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 3445 Hamilton St. Hoville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE FEB 10, 1969		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR, MD			
24. FUNERAL DIRECTOR W. W. CHAMBERS Co.		ADDRESS RODERDALE, MARYLAND		25a. REC'D BY REGISTRAR FEB 13 1969		25b. REGISTRAR'S SIGNATURE W. W. Chambers			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02837

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02831

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) First Middle Last James Ivan McMillan			2a. DATE KNOWN OF DEATH Month Day Year 2-15-69 19 9:10pm		
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 6-15-1925	6. AGE (in years last birthday) 43 YRS	7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 2 15 69 19 9:51pm
7a. BIRTHPLACE (State or foreign country) Wash. DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before) Maryland		13b. CITY OR TOWN Prince George's Carmody Hills		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME James F. McMillan		15. MOTHER'S MAIDEN NAME Bessie L. Williams 5435 C St SE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW2		17. INFORMANT Mrs Bertha O'Brien 1536 F F Davis St SE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral hemothorax DUE TO, OR AS A CONSEQUENCE OF Multiple rib fractures Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma - auto accident DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 8:49pm 2-15-69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver of car involved in collision	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory office building, etc.) Suitland Road, Suitland, Prince George County, Maryland		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Riverdale, Md.		22b. DATE SIGNED 2-16-69	
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE 2-21-1969		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	
24. FUNERAL DIRECTOR Henry S. Washington & Sons - 4925 Deane Ave, N.E.		23d. LOCATION (City or Town) (County) (State) Highland Park Md.		25a. REC'D BY REGISTRAR FEB 21 1969	
				25b. REGISTRAR'S SIGNATURE J. L. ...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
02838												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH			
Norris			Millard						Month Day Year			
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7b HOUR			
Male			Negro		7-31-1912		56 YRS.		3:45 P.M.			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
MARYLAND			U.S.A.				Prince George's County		Md.			
1d CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince George's Hospital		LABORER							
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b COUNTY		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		HIGHLAND PK. Rd.			
Maryland			Prince Geo. Landover				1104 70th Avenue					
14. FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			
Edward			Millard						ELIZABETH FLEET			
16a WAS DECEASED EVER IN U.S. ARMY FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT		Address					
NO			579-01-915		DOROTHY Millard		11815 Old Fort Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema												
4210 DUE TO, OR AS A CONSEQUENCE OF												
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)												
(b) Congestive Heart Failure												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
			HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION		Street or R.F.D. No		City or Town		
										County		
										State		
22a. I certify that (X) (this hospital) attended the deceased from 12/27/69 to 2/8/69, 1969, that (X) (we) last saw the deceased alive on Feb. 8, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death												
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22e. DATE SIGNED			
Joselito Magday, M. D.			M.D.						2-9-69			
22d. PHYSICIAN'S NAME (Type)			22f. ADDRESS									
			Prince Georges Gen. Hosp., Cheverly, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL			2-12-69		HARMONY PARK		LANDOVER		Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Rollins F.H.			4389 Hunt Pl. N.E. D.C.			DATE FEB 11 1968						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Georgia B. Miller						2/10/69			7:31 M
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Female	White		04/24/88			80 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Virginia		USA				Prince George's County Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George's Hospital			Housewife			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d. STREET AND NUMBER	
Maryland			PRINCE Geo.			Hyattsville		7304 Forrest Rd.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Elija M. Breeden			Christina C. Sellers						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			
no			579-01-7190			John Adams, Son 2028 Brooks Drive, Suitland, Md., 20028			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST.</u>									
4410 DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>DISSECTION OF LARGE CALCIFIED</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>AORTIC ANEURYSM</u>									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>OLD (L) HEMIPLEGIA</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>2-8</u> , 19 <u>69</u> , to <u>2-10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
Oliver B. Bond M.D.									2/10/69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Oliver Bond, M.D.					7420 Marlboro Pike, Forestville Maryland				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/12/69		Ft. Lincoln Cemetery		Washington, D. C.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert F. Wilhelm Funeral Home 4308 Suitland Rd., S. E., Suitland, Md. 20023					FEB 17 1969		[Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Louis			Miller			Month 2 Day 12 Year 69			8:15 AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		7 UNDER 24 HRS.	
MALE		CAUCASIAN		MARCH 16, 1883		85 YRS.		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		8 NEVER MARRIED		9 COUNTY OF DEATH			
RUSSIA		USA		WIDOWED		DIVORCED		PRINCE GEORGES COUNTY MD			
1d. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
HYATTSVILLE				HYATT'S NURSING HOME				REAL ESTATE			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MD.				PR. GEO.		SILVER SPRING		YES		NO	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First Middle Last				First Middle Last							
HARRY				MILLER		ROSE MILLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
UNKNOWN						VICKI CONNER, RN		213 Guilford Rd HYATTSVILLE, MD.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>ARTERIO SCLEROTIC HEART DISEASE; GEN. ARTERIO SCLEROSIS</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
<u>ARTERIO SCLEROTIC HEART DISEASE; GEN. ARTERIO SCLEROSIS</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
1-4-69		Nide Biopsy				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Yes.			
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19		Enter nature of injury in Part 1 or Part 2, Item 18.							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		(AT HOME, FARM, STREET FACTORY) OFFICE BUILDING, ETC.		Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1968</u> , to <u>2-12-69</u> , that (I) (we) last saw the deceased alive on <u>Feb. 4</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
<u>Irvin M. Grassgreen M.D.</u>		<u>2-12-69</u>									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
<u>IRVIN M. GRASSGREEN M.D.</u>		<u>3101 ARUNDEL RD. MT. LAIBER, MD.</u>									
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		County		State	
		<u>2/14/69</u>		<u>MT. LEBANON CEM.</u>		<u>HYATTSVILLE MD</u>					
24. FUNERAL DIRECTOR		ADDRESS		25. DEED BY REGISTRAR		25a. REGISTRAR'S SIGNATURE					
<u>BERNARD DANZANSKY SONS</u>		<u>3501-14th St N.W., D.C.</u>		<u>FEB 17 1969</u>		<u>WASH. D.C.</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or print)			First RORY			Middle JAMES			Last MILNER			2a DATE OF DEATH Month FEB Day 3 Year 69			2b HOUR 9:45 M		
3. SEX MALE			4. RACE CAUCASIAN			5. DATE OF BIRTH 15 NOV 59			6. AGE (In years last birthday) 9 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH PRINCE GEORGES			Md.					
10. CITY OR TOWN OF DEATH ANDREWS AFB			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give address) MALCOLM GROW USAF HOSP			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NA			12b KIND OF BUSINESS OR INDUSTRY NA								
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND			13b CITY OR TOWN PRINCE GEORGES			13c CITY OR TOWN SUITLAND			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 3007 PEARL DR APT 201					
14. FATHER'S NAME First GEORGE Middle LERoy Last MILNER JR.			15. MOTHER'S MAIDEN NAME First JOYCE Middle RAY Last MAJORS														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. NA			17 INFORMANT FATHER			Address SAME AS ITEM # 13								
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGENITAL LIVER DISEASE, ETIOLOGY ? DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Weeks 9 Years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Septicemia, E.Coli.																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 10 Jan , 19 69 , to 3 Feb , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3 Feb , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (do) (did not) view the body after death.																	
22b SIGNATURE <i>M. I. Horowitz</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED 3 Feb 69								
22d PHYSICIAN'S NAME (Type) M.I. HOROWITZ, CAPT, USAF MC						22e ADDRESS MALCOLM GROW USAFHOSP ANDREWS AFB MD											
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/7/69			23c. NAME OF CEMETERY OR CREMATORY Mt. Evergreen Cemetery			23d LOCATION (City or Town) (County) (State) Pecos, Texas								
24 FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, S. E., Wash., D.D. 20023						25a. REC'D BY REGISTRAR Feb 11 1969			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02842

02836

1. DECEASED NAME (Type or print) William B. Miltimore			2a. DATE OF DEATH Month 2 Day 10 Year 1969			2b. HOUR 12:03 P	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 03/06/95		6. AGE (In years last birthday) 75 YRS.	
7a. BIRTHPLACE (State or foreign country) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Confectionery		12b. KIND OF BUSINESS OR INDUSTRY Candy Co	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3141 Queens Chapel Road							
14. FATHER'S NAME First Albert Middle Gurney Last Bertie			15. MOTHER'S MAIDEN NAME First Bertie Middle Bryan Last Bryan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16b. SOCIAL SECURITY NO 577-03-0972		17. INFORMANT Clara Mae Miltimore Address Mt. Rainier, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Extensive Metastatic Adenocarcinoma of Liver DUE TO, OR AS A CONSEQUENCE OF (b) Sigmoid Carcinoma, Primary - Surgically resected. DUE TO, OR AS A CONSEQUENCE OF (c) 							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED Where <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-24 , 19 69 , to 2-10 , 19 69 , that (I) (we) last saw the deceased alive on 2-10 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William B. Hagan				22c. DATE SIGNED 2-10-69		22d. PHYSICIAN'S NAME (Type) William B. Hagan, M.D.	
22e. ADDRESS 6201 Riverdale RD. Riverdale, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 13, 1969		23c. NAME OF CEMETERY OR CREMATOR George Washington		23d. LOCATION (City or Town) (County) (State) Hyattsville Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR FEB 14 1969	
				25b. REGISTRAR'S SIGNATURE			



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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
Mildred		G.	Miracle	2-11 Month	Day 69 Year	10:40a
3. SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS
female	white		8-27-14		54 YRS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Virginia	USA				Prince George Md	
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Riverdale	Eugene Leland Memorial		Housewife		Own Home	
13a. USUAL RESIDENCE (Where deceased admiss on) STATE	13b. COUNTY		13c. STREET AND NUMBER			
Maryland	Prince George		Hyattsville YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6416 85th. Ave.,	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle Last
Richard			Sproles	Penny		Carmany
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address		
no, no, or unknown		403 05 6037		Roy A. Miracle (spouse) and Medical Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ILEUS - PERITONITIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SARcoma of uterus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
1-27-69		Sarcoma uterus		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1-23, 1969, to 2-11, 1969, that (I) (we) last saw the deceased alive on 2-11, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>R. F. Wilkinson</u>				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) <u>R. F. WILKINSON M.D.</u>				22e. ADDRESS		
				4408 Queensbury Rd., Riverdale, Md.		
23a. B. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)
Burial		2/14/69		Campbell Cemetery		Clear Fork Ky
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Hyattsville, Md				FEB 14 1969		<u>R. F. Wilkinson</u>

02847

02837

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15
30M REV 11/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH	2b. HOUR
BONNIE			SUE		MOORE		February 9		1969	230A M
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		7 IF UNDER 1 YEAR	
female		Caucasian		November 11, 1948			20 YRS.		MONTHS DAYS HOURS M N	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		United States		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince Georges County Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY	
Riverdale			Leland Memorial Hospital							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Pr Geo		College Pk		YES		4504 Fordham Lane	
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME	
Brady			M		Rossey				Marjorie Fitzhugh	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT				
no						LeCompte Funeral Service records				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH CAUSED BY:										
IMMEDIATE CAUSE (a) <u>pulmonary embolism</u>										
5670 DUE TO, OR AS A CONSEQUENCE OF <u>cause and condition</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>bronchitis & alcoholism</u>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										
22a. I certify that (I) (this hospital) attended the deceased from <u>1-4 - 1969</u> , to <u>2-8 - 1969</u> , that (I) (we) last saw the deceased alive on <u>2-8 - 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE						22c. DATE SIGNED				
<u>DR. R. D. R. MD</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial		Feb 11 1969		Dorchester Memorial Park			Cambridge, Maryland			
24 FUNERAL DIRECTOR						25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
LeCompte Funeral Service, Cambridge, Maryland						DATE FEB 11 1969				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
Item 17 Film 410 3/18/69 kk																	
02845																	
02842																	
1 DECEASED NAME (Type or print) Mason			First E.			Middle Neal			Last Sr.			2a. DATE OF DEATH Month February Day 23 Year 1969			2b. HOUR 7:30 MIN 00		
3 SEX Male			4 RACE Caucasian			5 DATE OF BIRTH 9-14-06			6 AGE (n years last birthday) 62			7 UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0			8 UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN 0		
7a BIRTHPLACE (State or foreign country) W. Va.			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince Georges			Md					
10 CITY OR TOWN OF DEATH Riverdale			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) E. Leland Mem. Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Truck Driver			12b KIND OF BUSINESS OR INDUSTRY Owner (Coal)								
13a USUAL RESIDENCE (Where deceased admission) STATE MD			13b COUNTY PR			13c CITY OR TOWN College Park			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 102-11 Ave.					
14 FATHER'S NAME John			First E.			Middle Neal			Last 10a			15 MOTHER'S MAIDEN NAME First Ida Middle Ida Last Bailey					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) no			(If yes give war or dates of service)			16b SOCIAL SECURITY NO 21-00-1111			17 INFORMANT Stella			Address Sella Jean Neal Same as #13 (wife)					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) 5409 PARALYTIC ILEUS												5 DAYS					
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPENDICEAL ABSCESS												1 WK					
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RENAL FAILURE																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)			21f LOCATION Street or RFD No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from JUNE , 19 65 , to 23 FEB , 19 69 , that (I) (we) last saw the deceased alive on 23 FEB , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE C. J. Houmann			DEGREE MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 24 FEB 69								
22d. PHYSICIAN'S NAME (Type) C. J. HOUMANN			22e. ADDRESS RIVERDALE MD.														
23a BURIAL, CREMATION REMOVED			23b. DATE 2-25-69			23c. NAME OF CEMETERY OR CREMATORY Roland & Bailey Funeral Home			23d. LOCATED ON (City or Town) (County) (State) Princeton, W. Va.								
24. FUNERAL DIRECTOR F. Gasch's Sons 4739 Balt. Ave. Hyattsville			ADDRESS			25a. REC'D BY REGISTRAR FEB 27 1969			25b. REGISTRAR'S SIGNATURE Charles Judge								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

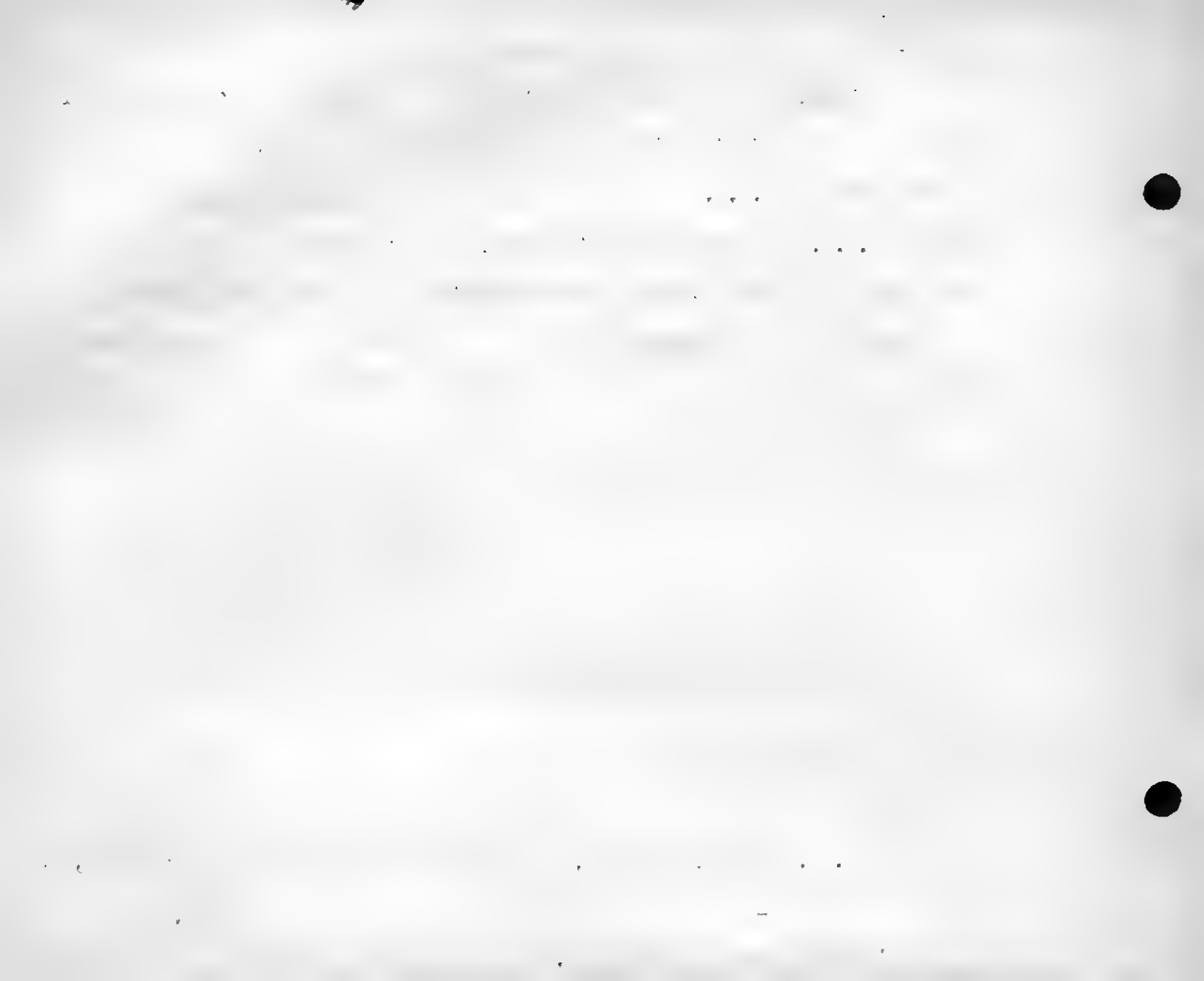
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Christine (NMN) Nelson						2a. DATE OF DEATH Month February Day 22 Year 69			2b. HOUR 3:20 PM		
3 SEX Female		4. RACE Cauc.		5. DATE OF BIRTH Jan. 4, 1895		6. AGE (In years last birthday) 74 YRS		IF UNDER 1 YEAR MONTHS 74 DAYS 00		IF UNDER 24 HRS. HOURS 00 MIN 00	
7a. BIRTHPLACE (State or foreign country) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. CITY OR TOWN Seabrook		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 9506 Underwood Street					
14. FATHER'S NAME First C. Middle I. Last Dahle				15. MOTHER'S MAIDEN NAME First Christy Middle Bjerva Last Bjerva							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 577 30 2663		17. INFORMANT Address Alfred N. Nelson Same as #13 (son)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LYMPHOMA SARCOMA DUE TO, OR AS A CONSEQUENCE OF (c) 8 years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 2-23-1967 to 2-26-1967 , that (I) (we) last saw the deceased alive on 2-22-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death											
22b. SIGNATURE Albert Roth, M. D.				DEGREE ALB. ROTH, M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-22-69			
22a. PHYSICIAN'S NAME (Type)				22e. ADDRESS 5409 Riverdale Rd., Riverdale, Md. 20840							
23a. BURIAL, CREMATION, or other disposition (Type) Burial		23b. DATE 2/26/69		23c. NAME OF CEMETERY OR CREMATOR Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore Baltimore Md.					
24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REG. CLERK FEB 26 1969		25b. REGISTRAR'S SIGNATURE Francis Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 File # 410 3-14-69a		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02843	
1 DECEASED NAME (Type or print) IRVING (NMI) NEUWIRTH			2a DATE OF DEATH FEB Month 25 Day 69 Year		2b HOUR 1130 M
3 SEX MALE	4 RACE CAUCASIAN	5. DATE OF BIRTH 4 NOV 1918		6. AGE (In years last birthday) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) NEW YORK	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH PRINCE GEORGES Md.		
10 CITY OR TOWN OF DEATH ANDREWS A.F.B.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAF HOSP	12a USUAL OCCUPATION (Kind of work done during most of work ng l.f.e, even if retired.) RETIRED	12b KIND OF BUSINESS OR INDUSTRY AF		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Res dence before admission) STATE MARYLAND	13b COUNTY PRINCE GEORGES	13c CITY OR TOWN CAMP SPRINGS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d INSIDE CITY LIM TSP	13e STREET AND NUMBER 4902 SHOPTON DRIVE	
14 FATHER'S NAME First PHILLIP Middle NEUWIRTH Last ETTA	15 MOTHER'S MAIDEN NAME First ETTA Middle SCHAFFERMAN Last				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT WIFE SAME AS ITEM #13 Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1890 Carcinoma failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Hypernephroma left kidney					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on 25 Feb 19 64 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE J. E. Willard	DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 25 Feb 69			
22d. PHYSICIAN'S NAME (Type) J. E. WILLARD, MAJ USAF, MC	22e. ADDRESS Malcolm Grow USAF Hosp Andrews AFB, Md				
23a. BURIAL, CREMATION, or other disposition BURIAL	23b. DATE 2-27-69	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Va.		
24. FUNERAL DIRECTOR Robert E. Wilhelm	ADDRESS 4308 Suitland Road	25a. REC'D BY REGISTRAR MAR 4 1969	25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
02845 Item 9 Film 6409 2/7/69 kk					02842 CERTIFICATE OF DEATH				
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) No. Brentwood				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital					d. STREET ADDRESS 4535 41st Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Daisy Ann Lawton					4. DATE OF DEATH Month Day Year 2 1 1969				
5. SEX F.		6. COLOR OR RACE Col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/27/85		9. AGE (In years last birthday) 78 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY ***		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Adams					14. MOTHER'S MAIDEN NAME Sallie Taylor				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 220-54-0658		17. INFORMANT Address 4535 41st Ave., Marie A. Walls daughter No. Brentwood, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Osteoarthritis								INTERVAL BETWEEN ONSET AND DEATH one week 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour p. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from Jan 4, 1969 to Feb 1, 1969, that (1) (we) last saw the deceased alive on Jan 31, 1969, and that death occurred at 11:45 AM, from the causes and on the date stated above.									
22a. SIGNATURE Benjamin S. Miller M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE Feb 1 1969		
22c. PHYSICIAN'S NAME (Type) BENJAMIN S MILLER MD					22d. ADDRESS 3824-34 ST MTRAINER MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 2/5/69		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cem.			23d. LOCATION (City, town, or county) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. M. Linn					ADDRESS 1820 9th St., N.W. Washington, D.C.		25a. REC'D BY REGISTRAR DATE FEB 4 1969		25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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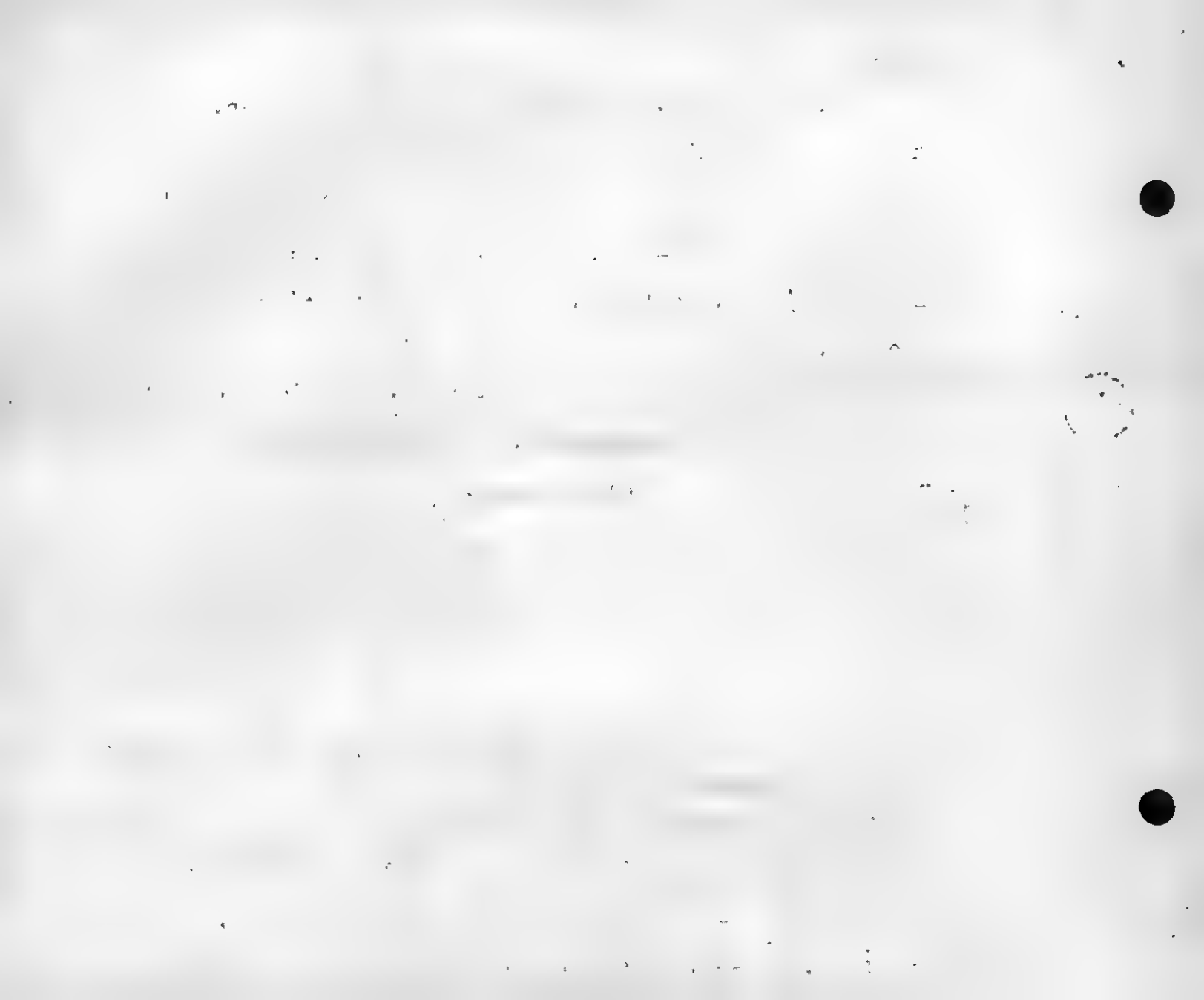
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02849

02845

1. DECEASED NAME (Type or print) MINNIE		First M. NYMAN		Middle		Last		2a. DATE OF DEATH Month Day Year Feb. 15-1969				2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 29, 1891				6. AGE (in years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.							
10. CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7477- Keystone Lane				12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Domestic			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Tane, KY		13b. COUNTY Pr. Geo's Co.		13c. CITY OR TOWN 7477- Keystone Lane SE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7477- Keystone Lane SE					
14. FATHER'S NAME John M. Mohl		First Middle Last		15. MOTHER'S MAIDEN NAME Minnie Garecht				First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Shirley E. Utterback . Same as # 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malignancy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Malegnancy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from June 1968, to Feb 14, 1969, that (I) (we) lost saw the deceased alive on 2-14-69 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE James C. Walsh MD		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-15-69			
22d. PHYSICIAN NAME (Type) JAMES C WALSH		22e. ADDRESS 730 24th ST. N.W.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 17-69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City or Town) (County) (State) Suitland, Maryland					
24. FUNERAL DIRECTOR Simmons Bros.		ADDRESS 1661-Gd. Hope Rd. SE. DC		25a. REG'D BY REGISTRAR DATE Feb 18 1969		25b. REGISTRAR'S SIGNATURE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Last Name also spelled O'Driscoll
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02850

CERTIFICATE OF DEATH

02846

1. DECEASED-NAME (Type or print) First Middle Last Annie - O'Driscoe			2a. DATE OF DEATH Month Day Year February 2 69		2b. HOUR 3:50PM
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH 07-02-94		6. AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince Georges Gen. Hosp.		12a. USLA. OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.	13b. CITY OR TOWN Prince Georges	13c. INS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER 6308 Pawhatan Street		
14. FATHER'S NAME First Middle Last Robert Bateman	15. MOTHER'S MAIDEN NAME First Middle Last Frances Burke				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 217 14 7335	17. INFORMANT John A O'Driscoe		Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subendocardial myocardial infarction.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Massive pulmonary embolism.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebrovascular accident.</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or RFD No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 31, 1969</u> to <u>Feb. 2, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb. 2, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Xavier</u>			DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) P.C. Xavier M.D.			22e. ADDRESS Prince Geo. Gen Hosp. Cheverly, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb 5, 1969	23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) Baltimore, Md.	(County) (State)
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 7 1969	25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MIDDLE										02847	
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
Andrew		E		Olsavsky		Olsavsky		Month 2 Day 23 Year 1969		5:45 PM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR
M	W	4 Dec. 1934		34 YRS	MONTHS DAYS		HOURS MIN		Month 2 Day 23 Year 1969		10:00 PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				Md	
Ohio		U.S.A.				Prince George					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Adelphi		9301 19th Avenue		Procurement Officer		U.S.A.					
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
Md.		Prince George		Adelphi				9301 19th Ave.			
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
Nicholas		--		Olsavsky				Mary		-- Chanda	
16a WAS DECEASED EVER IN U.S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		279-32-7806		Olsavsky		Adelphi, Md.					
				Marlene Olsavsky		9301 19th Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rupture of aneurysm of Circle of Willis										Minutes	
4307 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John Kenoe, M.D. Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 2-24-69	
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		2-27-1969		George Washington Cemetery		Prince Georges, Md.					
Funeral Director		C. Glen Carter		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
		C. Glen Carter, Inc. 843.1 Georgia Ave.		il. Sp. Md.		FEB 28 1969					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove lighter papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02859									
02843									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR A
Emma Owens						2/20/69			11:50M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		11/19/1894			74 YRS.		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Washington		D C		U.S.A.			Prince George's County Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Hospital Prince George's			housewife			home
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. STREET AND NUMBER	
Maryland			Prince Geo.			Tuxedo		5904 Arbor Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Christian			Burkley			Emma J Zells			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			
no			220 40 5085			George F Owens			
						Address Tuxedo, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Massive Pulmonary Thrombo-Embolism</u> 450X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from February 11, 1969, to February 20, 1969, that (I) (we) last saw the deceased alive on February 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Robert Deitz, M.D.						2/21/69		2/20/69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Robert Deitz, M.D.						Prince George's Plaza, Hyattsville, Md			
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		Feb 22, 1969		Ft Lincoln Cemetery			Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons Hyattsville, Md.						FEB 24 1969		H. Clonley, Registrar	

CERTIFICATE OF DEATH

02853

02849

1 DECEASED-NAME (Type or print) MATTIE E PADGETT			2a DATE OF DEATH Month 21 Day 69 Year 1969		2b HOUR 5:13A
3 SEX F	4 RACE W	5. DATE OF BIRTH 4/6/78		6. AGE (In years last birthday) 90 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH PR George Md		
10 CITY OR TOWN OF DEATH Clinton MD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pineview Gardens		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD COUNTY PG	13b CITY OR TOWN	13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 4200 Forestville Road		
14. FATHER'S NAME First Will Middle Carpenter Last			15 MOTHER'S MAIDEN NAME First Unknown Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-52-4514 B	17 INFORMANT Carl W. Robinson, Grandson Address 5346 Meadowview Dr., Suitland, Md., 20023		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4122 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac-pulmonary decompensation 2 mo. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic hypertension Cardiovascular Disease 25-6 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alfred R. Lapin, M.D.				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, MD				22e ADDRESS CLINTON, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 2/25/69	23c NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		23d LOCATION (City or Town) (County) (State) Forestville
24 FUNERAL DIRECTOR Robert L. Wilhelm Funeral Home 4303 Suitland Road., S.E. Washington, D.C. 20023				25a REC'D BY REGISTRAR FEB 26 1969	25b REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon of pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)					2a. DATE OF DEATH					2b. HOUR		
First Middle Last					Month Day Year					11:30 M		
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH-Time 02/19/69 3:28PM			6 AGE (In years lost birthday) YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's County Md						
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institut an admission) STATE Maryland		13b COUNTY Prince Geo.		13c CITY OR TOWN Beaver Hgts		13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1407 52nd Avenue				
14 FATHER'S NAME First Middle Last William Pannell					15 MOTHER'S MAIDEN NAME First Middle Last Catherine E. E. Edmonds							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY.												
IMMEDIATE CAUSE (a) <u>Primary Respiratory Failure</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) <u>Prematurity</u>												
DUE TO, OR AS A CONSEQUENCE OF												
stating the underlying cause last (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State		
						P.M.		P.M.				
22a I certify that (I) (this hospital) attended the deceased from 2/19/69 - 2/19/69, 11:30 P.M. (I) (we) last saw the deceased alive on 2/19/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <u>Edwin J. Jensen</u>			DEGREE Medical			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 2/21/69				
22d. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D. Director			22e ADDRESS Prince George's General Hospital									
23a BURIAL, CREMATION REMOVAL, SPECIFY Cremation		23b. DATE 3-7-69		23c NAME OF CEMETERY OR CREMATORY Pr. George's General Hosp.			23d LOCATION (City or Town) Cheverly, Prince Georges, Md.		(County)		(State)	
24 FUNERAL DIRECTOR <u>Harry W. Penn, Jr.</u>			ADDRESS Administrator			25a REC'D BY REGISTRAR DATE MAR 12 1969			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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02855

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
John				Louis	Payne	February 14, 1969			11:25 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Dec 20, 1902		66 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Va		U S A				Prince George's					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.			Retired foreman			Carpenter and Planing		
13a. USGA. RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Prince Geo.		E. Riverdale				5713 Somerset St.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Alfred N Payne						Loutridia					crouch
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
no			220 12 3296			Pearl L Payne			East Riverdale, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>gastrointestinal bleeding</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>errhorrhea of liver & gastroenteritis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>congestive heart failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Gangrene from venous stasis and cellulitis</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No			City or Town		County State
22a. I certify that (I) (the hospital) attended the deceased from <i>July 6th</i> , 1965, to <i>Feb 14th</i> , 1969, that (I) last saw the deceased alive on <i>Feb 14th</i> , 1969, and that in (my) low opinion death occurred on the date and hour and from the causes stated above, (I) low (a) low (b) low view the body after death											
22b. SIGNATURE <i>T. Ill Bergemann</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>Feb 15th 1969</i>		
22d. PHYSICIAN'S NAME (Type) T. Ill Bergemann, M.D.						22e. ADDRESS Prof. Bldg., Centerway, Greenbelt, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Feb 18, 1969		Prospect Cemetery			Mt Airy Carroll Md			
24. FUNERAL DIRECTOR F. Gasch's Sons						ADDRESS Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE FEB 19 1969		
									25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 411 MARYLAND STATE DEPARTMENT OF HEALTH
1-10-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02851

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR			
James Edward		Pinkney						12-13-69		19						M			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year		2d HOUR	
Male	Negro	7/8/34		34 YRS.		MONTHS		DAYS		2		13		69		19		M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH												Md	
Md		U.S.A				Prince George's													
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		2b KIND OF BUSINESS OR INDUSTRY													
Cheverly		Prince George Hospital																	
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY, WITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER											
Maryland		Prince George's		Fairmont Heights				722 60th Place											
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last					
Abraham Pinkney								Sarah Eaton											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS													
No		None		217-30-2504		Vivian Pinkney		7006 East											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Acute hemorrhagic pulmonary edema, right		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
191																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
		19																	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State									
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from.		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED															
EXAMINER'S NAME (Type)		John Kehoe MD		Riverdale, Md.		22c. DATE SIGNED		2-14-69											
23a BURIAL CREMATION, REMOVA. (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)									
		2-18-69		Lincoln		Switland Rd		Md											
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE													
H.S. Washington & Sons		4925 Deane Ave NE.D.C.		FEB 21 1969															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02857

CERTIFICATE OF DEATH

02852

1. DECEASED NAME (Type or print) First Middle Last Henry L. Posey		2a. DATE OF DEATH Month Day Year February 16 69		2b. HOUR 12:40 PM
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH 07-14-01	6. AGE (in years last birthday) 67 YRS	
7a. BIRTHPLACE (State or foreign country) Washington D C		7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Prince George's Md				
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince Georges Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Inspector	
12b. KIND OF BUSINESS OR INDUSTRY W S S C				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Prince Georges	13c. CITY OR TOWN College Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER 9001 St. Andrews Place				
14. FATHER'S NAME First Middle Last Henry N Posey		15. MOTHER'S MAIDEN NAME First Middle Last Laura Franklin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 577 48 0623	17. INFORMANT Address Sarah A Posey College Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				
PART I. DEATH WAS CAUSED BY:				
IMMEDIATE CAUSE (a) Massive Pulmonary Embolism.				
DUE TO, OR AS A CONSEQUENCE OF				
(b) Carcinoma Head of Pancreas/				
DUE TO, OR AS A CONSEQUENCE OF				
(c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
Post Whipple Procedure for Car Head of Pancreas				
19a. DATE OF OPERATION 2/5/69 9:40 PM	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Head of Pancreas		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 2/13/69 , 19 69 , to 2/16 , 19 69 , that (I) (we) last saw the deceased alive on 2/16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Jerome T. Sandler		DEGREE M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 2/17/69
22d. PHYSICIAN'S NAME (Type) Jerome Sandler, M.D.		22e. ADDRESS 106 Irving St., N.W., D.C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb 19, 1969	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md.		ADDRESS	25a. RECEIVED BY REGISTRAR FEB 21 1969	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
028558		028553							
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
POTTER		TEXANNA		TEXANNA		Feb. 18, 1969		2b. HOUR A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (n years last birthday)		7 UNDER 1 YEAR	
Female		Colored NEGRO		3/19/04		64 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Mid	
Alabama		U. S. A.				Prince George's			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's General		Housewife		at home			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Prince Georges		Chapel Oaks				1422 57th Place	
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Louis		Ford		Susie		Fredwell			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address		Dr.	
No		418-32-3719		Marie Cohen		1411-52nd Ave. N.E.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
174X		carcinomatosis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		carcinoma of breast 9-yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2/16, 1969, to 2/18, 1969, that (I) (we) last saw the deceased alive on 2/18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (d. not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)		Don B. Cameron, M.D.		3503 Perry Street, Mt. Rainier, Md.					
23a. RITUAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2-21-69		Parkland Memorial		Parkland Memorial, Md.			
24. FUNERAL DIRECTOR		1480 Chapel St		25a. REG'D BY REG. STRAR		25b. REG. STRAR'S SIGNATURE			
Dr. Behanbra		1480 Chapel St		FEB 24 1969		J. L. L. L.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coupon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
028559											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last James M. Power						2a. DATE OF DEATH 2/8/69 Month Day Year			2b. HOUR 7 P M		
3 SEX Male		4. RACE White		5. DATE OF BIRTH 10/28/94		6 AGE (In years last birthday) 74 YRS.		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Md		7b CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md					
10. CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Prince George's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Builder		12b. KIND OF BUSINESS OR INDUSTRY Building					
13a USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Prince Geo		13c. CITY OR TOWN Park University		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13a. STREET AND NUMBER 4216 Van Buren Street			
14 FATHER'S NAME First Middle Last John Power				15 MOTHER'S MAIDEN NAME First Middle Last Minerva Millican							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) yes W W I				16b SOCIAL SECURITY NO 216-03-4336		17 INFORMANT Ethel Lusby Power		Address University Park, Md.			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>											
Conditions, if any, which gave rise to immediate cause (a) <u>4 years</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ruptured Aortic Aneurysm</u> <u>10 hrs</u>											
stating the underlying cause lost (c) <u>Generalized Arteriosclerosis</u> <u>8 years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 2/8/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aortic Aneurysm				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> , 19 <u>61</u> , to <u>2/8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) view the body after death.											
22b. SIGNATURE <u>Norman Donald Comran</u>		22c. DATE SIGNED 2/8/69		22d. PHYSICIAN'S NAME (Type) Norman Donald Comran							
22e. ADDRESS 3503 Penryn St Prince Georges											
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 11, 1969		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 13 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 157
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR P M
George Thomas Proctor						2/25/69 Month Day Year			7:45 P M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Male	Negro		09/08/06			62 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH
Pr. Geo. Co. Md.			U.S.A.						Prince George's County Md.
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Hospital Prince George's						
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER
Maryland			Prince Georges			Upper Marlboro			3745 Van Brady Road
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Robert Naylor			Rosetta Proctor						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address
			579-28-1356			Mary U. Proctor			Above
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Old Subendocardial Infraction Massive</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Bilateral Polycystic Kidney</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natally medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> , 19 <u>69</u> , to <u>2/25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/25</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
Edwin J. Jense, M.D.			2/27/69						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
Edwin J. Jense, M.D.			Prince Geo. General Hosp., Cheverly, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			3-1-69			Resurrection Cemetery			Clinton, Pr. Geo's, Md.
24. FUNERAL DIRECTOR			ADDRESS			25a. RECORD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE
Martell Adams			Aguasco, Md.			MAR 4 1969			John J. Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <i>Clara L. Radcliffe</i>						2a DATE OF DEATH Month <i>2</i> Day <i>20</i> Year <i>1969</i>			2b HOUR <i>4:15</i> P.M.		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>02/14/85</i>		6 AGE (In years last birthday) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>England</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Prince George's County</i> Md					
10 CITY OR TOWN OF DEATH <i>Cheverly</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Prince Georges Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		
13a USUAL RESIDENCE (Where deceased lived, if not in institution - Residence before admission) STATE <i>Maryland</i>			13b COUNTY <i>Prince Geo.</i>			13c CITY OR TOWN <i>Landover Hills</i>		13d INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>6912 Varnum Street</i>	
14 FATHER'S NAME First <i>Wm C</i> Middle <i>Thompson</i> Last <i>Hills</i>				15 MOTHER'S MAIDEN NAME First <i>Emma J.</i> Middle <i>Miller</i> Last <i></i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <i>no</i> (If yes give war or dates of service)			16b SOCIAL SECURITY NO. <i>577 10 4854D</i>		17. INFORMANT <i>J. T. Radcliffe</i>			Address <i>Landover Hills, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>72 hrs.</i> <i>15 years.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic bronchiectasis & emphysema</i> <i>10 years.</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME - FARM STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 15, 1969</i> to <i>Feb 20, 1969</i> , that (I) (we) last saw the deceased alive on <i>Feb 20, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.											
22b. SIGNATURE <i>Thomas G. Moloney, M.D.</i>						22c. DATE SIGNED <i>20 Feb 69</i>					
22d. PHYSICIAN'S NAME (Type) <i>Thomas G. Moloney, M.D.</i>						22e. ADDRESS <i>Prince George's Hospital, Cheverly, Md.</i>					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>Feb 22, 1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Washington D. C.</i>					
24 FUNERAL DIRECTOR <i>F. Gasch's Sons Hyattsville, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>FEB 24 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William Under</i>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH	
Philip			John		Raymond				<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 2-19-69 19 2:25am	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	7. UNDER 1 YEAR		8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d HOUR
Male	White	1-23-1908	61 YRS	MONTHS DAYS		HOURS MIN		Month Day Year 2 19 69 19 2:30am		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH		10a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
Pa		U S A		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's		Painter		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital			Painter			Construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET AND NUMBER	
Maryland			Prince George's Riverdale			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5416 55th. Place	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
Philip Raymond			Elizabeth Thomas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS	
			577 18 4062			Philip Raymond			Jr Falls Church Va.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u>										
DUE TO, OR AS A CONSEQUENCE OF <u>Oat cell carcinoma of lung</u>										over 3 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
CAUSE OF DEATH			HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			22b. DATE SIGNED							
John Kehoe MD			2-20-69							
EXAMINER'S NAME (Type)			23a. LOCATION (City or Town) (County) (State)							
Riverdale, Md.			Hyattsville Pro Geo Md.							
23a. B. RIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. REC'D BY REGISTRAR	
Burial			Feb 22, 1969			Geo Washington Cemetery			FEB 24 1969	
24. FUNERAL DIRECTOR			25a. REG STRAR'S SIGNATURE							
F. Gasch's Sons			Hyattsville, Md.							

CERTIFICATE OF DEATH

02863

02858

1. DECEASED-NAME (Type or print) Charles Henry Redman			2a. DATE OF DEATH Month February Day 20 Year 1969			2b. HOUR 9:30PM	
3 SEX Male		4 RACE Negro		5. DATE OF BIRTH 10/26/34		6. AGE (In years last birthday) 34 YRS. MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) West. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Prince George's		12a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired) Salesman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S. RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Pleasant		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER 6531 C Street	
14. FATHER'S NAME James C. Redman			15. MOTHER'S MAIDEN NAME Rosie L. Brown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 236-42-0579		17. INFORMANT Margaret Redman		Address 6531-C-St. Md. Park	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MASSIVE SUBARACHTNOID HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/14/69 , 19____, to 2/20/69 , 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arthur Litofsky M.D.				DEGREE ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. DIRECTOR PHYS.		22c. DATE SIGNED 2/22/69	
22d. PHYSICIAN'S NAME (Type) Arthur Litofsky, M.D.				22e. ADDRESS 1015 Spring St., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-26-69		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK		23d. LOCATION (City or Town) (County) (State) LANDOVER, MARYLAND	
24. FUNERAL DIRECTOR Reliance Funeral Home 4339-Hunt Pk. N.E.				25a. REC'D BY REGISTRAR DATE FEB 25 1969		25b. REGISTRAR'S SIGNATURE John J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR		
Janie			Reed			DATE MATED <input checked="" type="checkbox"/> 2-19-69		1985 04am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		
Female	Negro	9-5-1911	57 YRS					2d HOUR		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Washington, D.C.			USA				Prince George's			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Dietician				
13a USUAL RESIDENCE (Where deceased lived, if in institution - Residence before death)			13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		13f	
District Of Columbia			Washington				116 Kentucky Ave., S.E.			
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			First Middle Last				
James Reed			Mary Frances Queen							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
					Miss Marion Reed-6232 Clay St., N.E.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral hemothorax										
DUE TO, OR AS A CONSEQUENCE OF Multiple bilateral rib fractures										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
		8:00am 2-19- 19 69		Passenger in car which ran off road and hit a tree.						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
		1700 block of 62nd. Ave., Cheverly, Prince George County, Md.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			2-20-69				
John Kehoe MD Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			2/22/69		Lincoln Memorial Cemetery Maryland					
24 FUNERAL DIRECTOR			25a RECEIVED BY REGISTER		25b REGISTERED SIGNATURE					
Stewart Funeral Home-4001 Benning Road, N.W.			FEB 26 1969							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

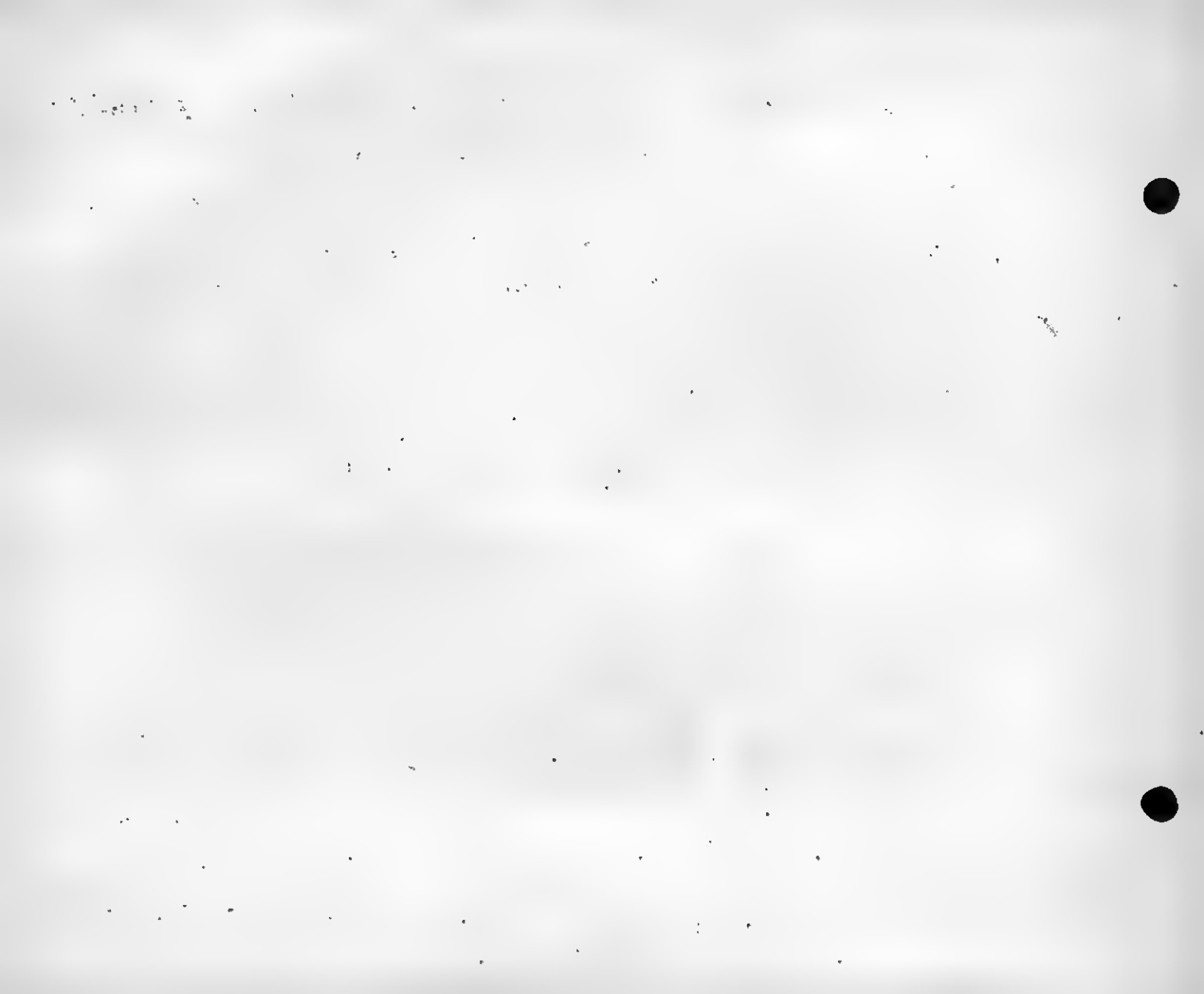
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

028865

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) ISABELLA		First D.		Middle R.		Last Keith		2a. DATE OF DEATH 2 Month 10 Day 1969		2b. HOUR 4:45 A M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH 8-27-1882		6 AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Prince George Md					
10. CITY OR TOWN OF DEATH Hyattsville Md		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3801-42nd Ave		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Prs Geo		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7511 Grand St			
14 FATHER'S NAME Stuart Donaldson		First Stuart		Middle Donaldson		15 MOTHER'S MAIDEN NAME Margaret Smith		First Margaret		Middle Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 579326437A		17 INFORMANT Wm C. Keith College Park, Md Address							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY. 412.3 IMMEDIATE CAUSE (a) Complete Heart Block DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1962 , to 2-10 , 19 69 , that (I) (we) lost the deceased alive on 2-8 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Donald C. Edgren		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-10-69					
22d. PHYSICIAN'S NAME (Type) DONALD C. EDGREN		22e. ADDRESS 6281 Prospect Road College Park, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 12, 1969		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City or Town) Falls Church		(County) Rairfax		(State) Va	
24. FUNERAL DIRECTOR F. Gassh's Sons Hyattsville, Md.				ADDRESS		25a. REC'D BY REGISTRAR FEB 14 1969		DATE		25b. REGISTRAR'S SIGNATURE [Signature]	



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02866		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02861	
Items 5&6 Film 411 4/8/69 kk					
1 DECEASED-NAME (Type or print) Martha			First Rheinfrank		2a. DATE OF DEATH Month 2 Day 28 Year 69
3 SEX female			4 RACE white	5 DATE OF BIRTH Dec 29 1877	6 AGE (In years last birthday) 91 93 YRS
7a BIRTHPLACE (State or foreign country) Germany		7b CIT ZEN OF WHAT COUNTRY? U S A	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges	
10 CITY OR TOWN OF DEATH Hyattsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Madison Manor Nursing		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Housewife	
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE Maryland		13b COUNTY Pro. Geo.	13c CITY OR TOWN SeaBrook	3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 9617 Woodberry St.
14 FATHER'S NAME First /? Middle Siemers			15 MOTHER'S MAIDEN NAME First ? Middle ? Last ?		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b SOCIAL SECURITY NO. 215 46 2503		17 INFORMANT Joy DeArce Address Same as 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hypertensive vascular disease 15 yrs. (b) Hypertensive vascular disease 15 yrs. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or RFD No City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from Jan 1958 to 2/28/69 , that (I) (we) last saw the deceased alive on 2/28/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Fred Musser				22c. DATE SIGNED 2/28/69	
22d. PHYSICIAN'S NAME (Type) Fred Musser				22e ADDRESS Lanham, Md	
23a BURLIAL, CREMATON, REMOVAL (Specify) Burial		23b DATE 3/3/69		23c NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	
24. FUNERAL DIRECTOR F. Gasch's /Funeral Home		ADDRESS Hyattsville, Md		25a REC'D BY REGISTRAR DATE MAR 4 1969	
				25b REGISTRAR'S SIGNATURE Charles Jones	
23d LOCAT ON (City or Town) Milwaukee		(County) Milwaukee		(State) Wis.	

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VR A13
30M REV.

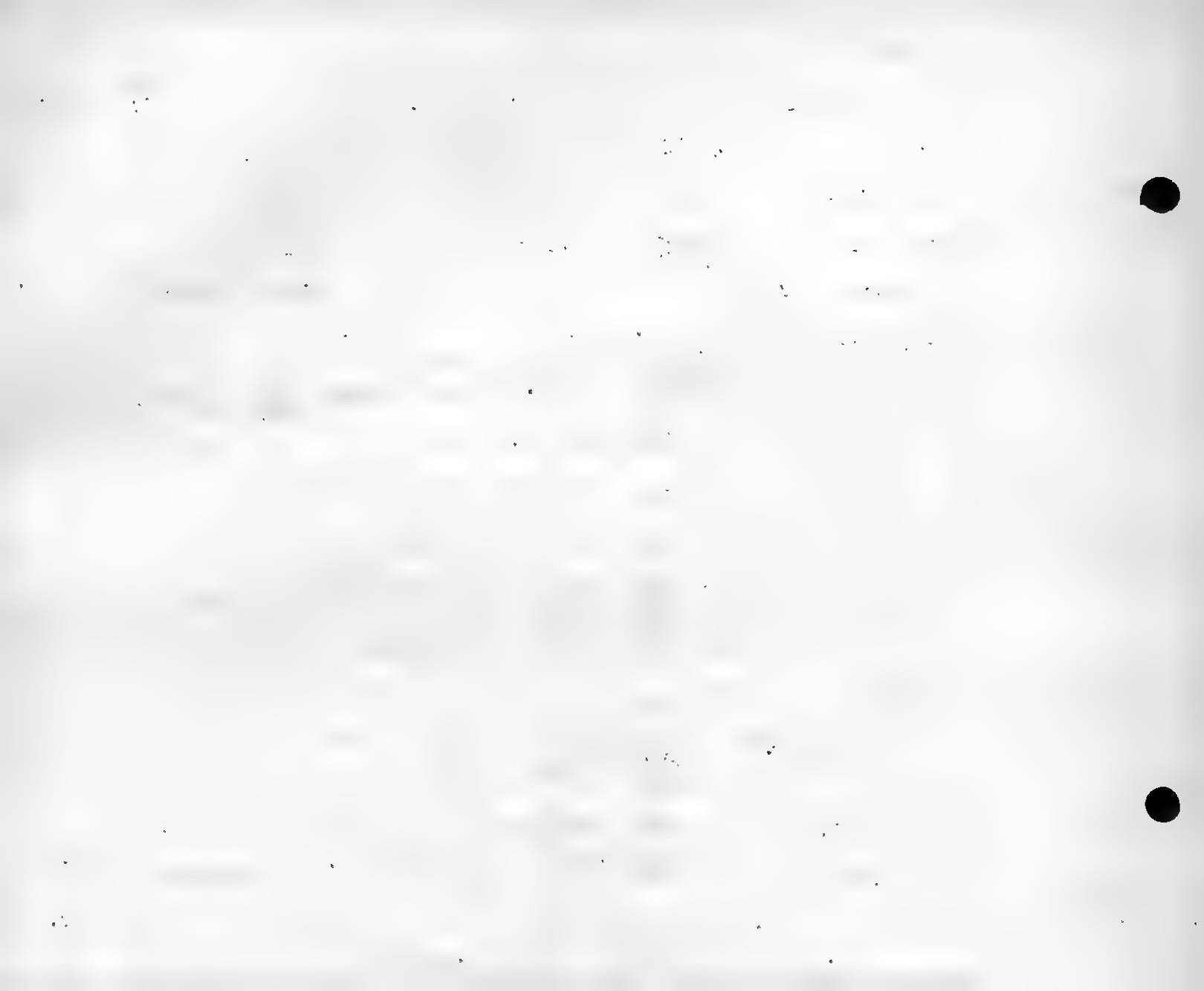
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02867

02862

1 DECEASED NAME (Type or print) First Middle Last JAMES B. Richardson		2a. DATE OF DEATH Month Day Year FEB 13 1969		2b. HOUR 8:45 a.m.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 1, 1880		6. AGE (In years last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) South Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY P
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE COUNTY WASH. D.C.		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1336 Anacostia Rd. S.E.	
14. FATHER'S NAME First Middle Last Charles Louis Richardson		15. MOTHER'S MAIDEN NAME First Middle Last Mary Major			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 577-16-6130	17. INFORMANT CHART Address Hyattsville Nursing Home 6500 Riggs Rd. Hyatts. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1) Chronic brain syndrome 2) Diverticulitis					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 11/29, 1968 , to 2/13, 1969 , that (I) (we) last saw the deceased alive on 2/13, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Norman H. Rubenstein MD		22c. DATE SIGNED 2/13/69		22d. PHYSICIAN'S NAME (Type) NORMAN H. RUBENSTEIN	
22e. ADDRESS 11161 N.H. Ave. Silver Spring, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE Feb 15, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE FEB 17 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> 02863 CERTIFICATE OF DEATH 02863 </div>										
1 DECEASED NAME (Type or print) Jessie L. Rings					2a. DATE OF DEATH 2/3/69					2b. HOUR 11:55 PM
3 SEX Female		4. RACE White		5. DATE OF BIRTH 08/10/91		6 AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Missouri		7b. CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges's County Md				
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Economist		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4104 College Height Drive		
14 FATHER'S NAME George W Ramey				15 MOTHER'S MAIDEN NAME Henrietta Sproule						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 514.05.7754		17 INFORMANT Eleanor Rings. same as # 13e						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Congestive Heart Failure										
DUE TO, OR AS A CONSEQUENCE OF with perforation.										
(b) Acute Bacterial Endocarditis of Aortic Valve										
DUE TO, OR AS A CONSEQUENCE OF with perforation.										
(c) Acute Bacterial Endocarditis of Aortic Valve										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Acute Splenic Infarct.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from Jan 9, 1969 to Feb 3, 1969 , that (I) (we) last saw the deceased alive on Feb 3, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Don B. Cameron				DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Feb 4, 1969		
22d. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D.				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2.6.69		23c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery Darnestown, Maryland		23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR See Funeral Home 300-4444 D.C.				ADDRESS Spash & C		25a. REC'D BY REGISTRAR FEB 13 1969		25b. REGISTRAR'S SIGNATURE 38		

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02869

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02864

1 DECEASED NAME (Type or print) CAROLINE W. ROBERTS			2a. DATE OF DEATH Month Feb. Day 18 Year 1969			2b. HOUR 1:45 AM	
3 SEX FEMALE		4. RACE W.		5. DATE OF BIRTH 1-11-1978		6 AGE (In years last birthday) 91 YRS.	
7a. BIRTHPLACE (State or foreign country) Van West - Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH P.G.C. PRINCE GEORGE'S Md	
10. CITY OR TOWN OF DEATH Ghent, Md.		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Ghent Conv. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Teacher		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND		13b. COUNTY PRINCE GEORGE'S		13c. CITY OR TOWN SEABROOK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Isiah H. Wilmore Middle Last 		15. MOTHER'S MAIDEN NAME First Mary Jane Middle Adelle Last 		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of serv. ca.) NO		16b. SOCIAL SECURITY NO 335106449A	
17. INFORMANT MRS JOAN KLIMA		18. ADDRESS SAM'S A.S. # 13.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia - 4 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure - DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NO							
19a. DATE OF OPERATION NO		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NOT CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour AM 19 Month 19 Day 19 Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9/14/1967 , to 2/18/1969 , that (I) (we) last saw the deceased alive on 2/18/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ann V. Magal M.D.		22c. DATE SIGNED 2/18/69		22d. PHYSICIAN'S NAME (Type) I.V. MAGAL M.D.		22e. ADDRESS 2650 Virginia Ave. N.W.	
23a. BURIAL, CREMATION, REMOVA (Specify) CREMATION		23b. DATE 2-18-1969		23c. NAME OF CEMETERY OR CREMATORY H. LINCOLN CEM.		23d. LOCATION (City or Town) (County) (State) COLMAR MAJOR, MARYLAND	
24. FUNERAL DIRECTOR W. W. Chambers to Riverdale, Md.		25a. REC'D BY REGISTRAR DATE 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

30 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
028570												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year			
Fernel1			Robinson						2b. HOUR 11:30 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Male		Negro		4/8/12			56 YRS.		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Virginia		USA				Prince George's Md						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Glenn Dale, Md.			Glenn Dale Hospital			Floor Man			--			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
D.C.			Wash., D.C.					1252 Columbia Road, N. W.				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			
Unknown									Laura Robinson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
No			231-22-6438			Decedent						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. Metastatic carcinoma to liver (biopsy proven), IMMEDIATE CAUSE (a) epidermoid type, primary site undetermined 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary tuberculosis.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from 12/3, 1968, to 2/22, 1969, that (X) (we) last saw the deceased alive on 2/22, 1969, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Moe Weiss						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2/22/69				
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.						22e. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or town)		(County) (State)		
Removal			3-10-69		ANATOMICAL BOARD			Newport, News Va.		Washington, D. C.		
24. FUNERAL DIRECTOR R. N. Horton Funeral Home Inc 1324 You, St. N. W.						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE MARI 2 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR			
Goldie E. Roessler						2/9/69			9:15 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		White		08/10/98			70 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Iowa		U. S. A.					Prince George's County			Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
NEW YORK Cheverly			Prince George's Hospital									
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. CITY OR TOWN			13c. INS OR CITY LIMITS?			13e. STREET AND NUMBER			
New York			Brooklyn			YES <input type="checkbox"/> NO <input type="checkbox"/>			216 Windsor Place			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Daniel M. Williams			Lillie B Vallier									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address			
Yes, no or unknown			086-03-4833			William C. Ringe Funeral Home			Brooklyn N.Y.			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1: DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										12 hrs		
(b) <u>atrial fibrillation</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
<u>Intestinal obstruction</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
1-30-69						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If injury, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			19									
21d. INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION			City or Town County State			
						Street or R.F.D. No						
22a. I certify that (I) (this hospital) attended the deceased from <u>1/21/69</u> , 19 <u>69</u> , to <u>2/9/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/8/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE						DEGREE			22c. DATE SIGNED			
<u>Julius Kauffman</u>						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			2/10/69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
Julius Kauffman, M.D.						6501 Landover Rd., Cheverly, Md.						
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			2/13/69			Lutheran Cemetery			Middle Village N.Y.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
W. A. R. Huntemann & Son 5732 Georgia Ave N.W. Washington, D.C.						FEB 13 1969						

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items 5&6 Film 410 3/10/69 kk											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Bernice		Middle Monice		Last Rosser		2a DATE OF DEATH Month Day Year 2/18/69		
3 SEX Female			4 RACE White		5 DATE OF BIRTH 1884 Feb 10, 1884		6 AGE (in years last birthday) 86 YRS		7b UNDER 1 YEAR MONTHS DAYS 7b UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Va			7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's County Md				
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Prince George's		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY Saleslady				
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland			13b COUNTY PG.		13c CITY OR TOWN Seabrook		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 9767 Telegraph Road		
14 FATHER'S NAME First Middle Last John Boze			15 MOTHER'S MAIDEN NAME First Middle Last Ellen Knowles								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) no			16b SOCIAL SECURITY NO. (If yes give war or dates of service) unknown		17 INFORMANT Kathryn O'Connor		Address Seabrook, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) Pernicious anemia DUE TO, OR AS A CONSEQUENCE OF (c) Thrombocytopenia - Bleeding diathesis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a I certify that (I) (this hospital) attended the deceased from 2/6/69, 19__, to 2/18/69, 19__, that (I) (we) lost saw the deceased alive on 2/18/69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Xavier						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 2/19/69		
22d PHYSICIAN'S NAME (Type) D.C. Xavier, M.D.						22e ADDRESS Prince George's General Hospital					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE Feb 22, 1969		23c NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery			23d LOCATION (City or Town) (County) (State) Lynchburg Campbell Va			
24. FUNERAL DIRECTOR F. Gasch's Sons						ADDRESS Hyattsville Md.			25a REC'D BY REGISTRAR FEB 24 1969		
						25b REGISTRAR'S SIGNATURE Xavier					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02867	
1. DECEASED-NAME (Type or Print) <u>a/k/a Catherine R. Speakes</u> <u>Catherine Rosetta Rothwell</u>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> <u>2-14-69</u> 19 <u>11</u> <u>13</u> am	
3 SEX <u>Female</u>	4 RACE <u>Negro</u>	5 DATE OF BIRTH <u>1-2-1925</u>	6 AGE (In years last birthday) <u>44</u> YRS	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS HOURS <u> </u> MIN <u> </u>		2c. DATE PRONOUNCED DEAD Month <u>2</u> Day <u>14</u> Year <u>69</u> 19 <u>11</u> <u>32</u> am		2b. HOUR	
7a. BIRTHPLACE (State or foreign country) <u>D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George's</u>				2d. HOUR	
10. CITY OR TOWN OF DEATH <u>Cheverly</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Prince George Hospital</u>		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Clerk</u>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Prince George's</u>		13c. CITY OR TOWN <u>Palmer Park</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>8119 Burnside Road</u>			
14. FATHER'S NAME First <u>Alonzo</u> Middle <u>Thompson</u> Last <u> </u>				15. MOTHER'S MAIDEN NAME First <u>Ruth</u> Middle <u>Steele</u> Last <u> </u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <u>Lillian Thomas</u>		ADDRESS <u>3700 9th. Street, S.E.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF <u> </u> (c) <u> </u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>over 5 mo.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u> </u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Kehoe MD</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>2-15-69</u>			
EXAMINER'S NAME (Type) <u>John Kehoe MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county) <u>Riverdale, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL <u>Buried</u>		23b. DATE <u>2/18/1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>		23d. LOCATION (City or Town) <u>Suitland, Maryland</u> (County) <u> </u> (State) <u> </u>					
24. FUNERAL DIRECTOR <u>W. Ernest Jarvis Co., Inc. 1432 You St., N.W.</u>						25a. REC'D BY REGISTRAR <u>FEB 20 1969</u>		25b. REGISTRAR'S SIGNATURE <u>W. Ernest Jarvis</u>			

**FOR STATE
HEALTH DEPT.**

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02868

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
Joseph Edward Routten								2-17-69		12		10		PM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
Male	White	3-14-1885		83 YRS		MONTHS		DAYS		2		17		69		12:10 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH									
Va		U S A		WIDOWED		DIVORCED		Prince George's								Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
Cheverly		Prince George Hospital		Retired Salesman		Bakery											
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Maryland		Prince George's		Colmar Manor		YES		3600 43rd. Avenue									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
J E Routten								Emily									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS											
no		578 01 2872A		Virginia A Bennett		Colmar Manor, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure																hours	
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease																years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
Parkinson's Disease - years																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES					
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
CAUSE OF DEATH				HOUR A.M. P.M.				19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				City or Town					
WHILE AT WORK				factory, office building, etc.)				City or Town				County					
NOT WHILE AT WORK												State					
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from Natural causes, Accident, Suicide, Homicide, Undetermined manner																	
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED									
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				2-18-69									
John Kenoe MD				DEPUTY MEDICAL EXAMINER													
Riverdale, Md.				ADDRESS (Street, city, town, or county)													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)					
Burial				Feb 20, 1969				Ft Lincoln Cemetery				Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REGISTRAR				25b. REGISTRAR'S SIGNATURE					
F. Gasch's Sons				Hyattsville, Md.				FEB 24 1969									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Part 1, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2-25-69 19 8:05pm		2b. HOUR	
Hyman Rubenstein									
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Male	White	12-10-1900	68 YRS			2 25 69		19 9:40pm	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
England		U. S. A.				Prince George's			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland Park			211 65th. Avenue			Merchant		Grocery	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY L.M. 157 YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland				Prince George's		Hillside		1313 50th. Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Barnett Rubinstein			Flora Raskin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			219-12-9125		8107 Eastern Avenue Betty Deckelbaum Silver Spring, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u> <u>965X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 8:00pm 2-25-69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot during robbery				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 211 65th. Avenue, Maryland Park, Prince George County, Maryland			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			John Kehoe MD Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 2-26-69	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2-28-1969		Beth Shalom Cemetery		Capitol Heights, Md.		
24. FUNERAL DIRECTOR ADDRESS					25a. RECD BY REGISTRAR DATE MAR 4 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		
Goldberg Funeral Home 4217 9th St., N.W.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR A.M. P.M.	
Philip Truxton Russell					Feb. 27, 1969			6:05 A.M.	
3. SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS. HOURS MIN.
Male	White		12/24/93		75 YRS.				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maine	U.S.A.				Prince George's Md.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince Geo. General Hosp.			Engineer-U.S.Govt.				
13a USUAL RESIDENCE (Where deceased lived, if institution. Res. dence before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland		Prince George's		Hyattsville	YES		3823 Hamilton Street		
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last					
Howard I. Russell				Grace Walker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service.)		16b. SOCIAL SECURITY NO		17 INFORMANT Address					
NO		217-46-8060		Emma B. Russell (above address) (Wife)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Thrombotic Occlusion, right coronary artery</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe stenosing coronary arteriosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1-1960</u> to <u>2-27-1969</u> , that (I) (we) last saw the deceased alive on <u>2-27-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Aaron Deitz</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>2-27-69</u>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Aaron Deitz, M.D.				Prince Geo. Plaza, Hyattsville, Md.					
23a. BURIAL, CREMATION, BY OTHER MEANS		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/1/69		Ft. Lincoln Cem.		Colmar Manor, Md.			
24. FUNERAL DIRECTOR Name (Type)				ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
Nalley's Funeral Home Inc.				Mt. Rainier, Maryland		MAR 4 1969		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13 See birth cert.		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02877		02871	
1 DECEASED-NAME (Type or print) CHRISTINA SALES SAMONTE				2a. DATE OF DEATH FEB Month 25 Day 69 Year		2b. HOUR 8:45 M	
3. SEX Female		4 RACE Caucasian		5. DATE OF BIRTH 24 Feb 69		6. AGE (In years last birthday) — YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH PRINCE GEORGE Md	
10 CITY OR TOWN OF DEATH ANDREWS A.F.B.		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital) MALCOLM GROW USAF HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NA		12b. KIND OF BUSINESS OR INDUSTRY NA	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before death) MARYLAND D.C. PRINCE GEORGE		13c. CITY OR TOWN (If in institution) CAMP SPRINGS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER NAVAL HOUSING 4-OCEAN GREEN SW	
14 FATHER'S NAME First Middle Last FLORANDE BANGANIBAN SAMONTE				15 MOTHER'S MAIDEN NAME First Middle Last CARMENCITA BEGONIA SALES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) NO		16b. SOCIAL SECURITY NO.		17 INFORMANT Address Mother Same As Item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) IMMATUREITY 11/11X DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
9a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (a) (this hospital) attended the deceased from 24 Feb , 19 69 , to 25 Feb , 19 69 , that (a) (we) lost saw the deceased alive on 25 Feb , 19 69 , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (a) (did) not view the body after death.							
22b. SIGNATURE M. I. Horowitz				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 25 Feb 69	
22d. PHYSICIAN'S NAME (Type) M.I. HOROWITZ, CAPT USAF MC				22e. ADDRESS MALCOLM GROW USAFH ANDREWS AFB MD			
23a. BURIAL CREMATION REMOVAL (Specify) Cremation		23b. DATE 3/7/69		23c. NAME OF CEMETERY OR CREMATOR DC General Hospital		23d. LOCATION (City or Town) (County) (State) Washington DC	
24 FUNERAL DIRECTOR Carl F. Oupf...				25a. REC'D BY REGISTRAR MAR 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

ATTESTED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
1 DECEASED-NAME (Type or print)			First Pearl			Middle R			Last Schandl			2a DATE OF DEATH Month 02			Day 03			Year 1969			2b HOUR 7:00 PM		
3 SEX Female			4 RACE Caucasian			5. DATE OF BIRTH 07-02-27			6 AGE (In years last birthday) 71			F UNDER 1 YEAR MONTHS			F UNDER 24 HRS. DAYS			F UNDER 24 HRS. HOURS			F UNDER 24 HRS. MIN		
7a BIRTHPLACE (State or foreign country) Washington, D.C.			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's County Md														
10 CITY OR TOWN OF DEATH Riverdale			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Men. Hos.			12a USAL OCCUPATION (Kind of work done during most of working life, even if retired) Sales Lady			12b KIND OF BUSINESS OR INDUSTRY Store														
13a USUAL RESIDENCE (Where deceased admission) STATE District of Columbia			13b COUNTY 136 COUNTY			13c CITY OR TOWN Washington			13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 1823 Q Street S.E.											
14 FATHER'S NAME First William			Middle Jones			Last Taylor			15 MOTHER'S MAIDEN NAME First Grace			Middle Taylor			Last Taylor								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b SOCIAL SECURITY NO. No			17 INFORMANT John Schandl			Address 1823 Q St. S.E. Washington, D.C.														
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiogenic Carcinoma of Lung with Metastases</u> <u>Liver, Lymph Nodes and Spine</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a DATE OF OPERATION -- -- --			19b CONDITION FOR WHICH OPERATION WAS PERFORMED -- -- --						20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) XX			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from July 19 66, to February 8 19 69, that (I) (we) last saw the deceased alive on February 7, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.																							
22b SIGNATURE Walcutt W. Gibson, M.D.												22c. DATE SIGNED February 8, 1969						22d PHYSICIAN'S NAME (Type) Walcutt W. Gibson, M.D.					
22e ADDRESS 4300 St. Barnabas Road Marlow Heights, Md. 20031																							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 2.12.69			23c NAME OF CEMETERY OR CREMATORY Washington National						23d LOCATION (City or Town) (County) (State) Suitland. Maryland											
24 FUNERAL DIRECTOR Lee Funeral Home. 300.4th st N E												25a REC'D BY REGISTRAR DATE FEB 11 1969						25b REGISTRAR'S SIGNATURE Charles Judge					

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH		
Baby			Tamara		Schram		Feb. 27, 1969		2b. HOUR 6 P.M.		
3. SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		2/18/69			YRS		MONTHS		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		IF UNDER 24 HRS.		
Maryland		U S A					Prince George's		9		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's General								
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Prince Georges		Lanham				5624 Whitfield Chapel Rd.		
14 FATHER'S NAME			15 MOTHER'S M.A.DEN NAME								
First Middle Last			First Middle Last								
Frederick Schram			Jo Anne Welmen								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT			Address			
no			None		Frederick G Schram			Lanham, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M.									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 2/18/69, 19, to 2/27/69, 19, that (I) (we) last saw the deceased alive on 2/27/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
Patrick A. Reardon M.D.						2-27-69					
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS					
Patrick A. Reardon, M.D.						9430 Lanham-Severn Road, Seabrook Md.					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		March 1, 1969		Mt Olivet Cemetery		Washington D. C.					
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
F. Gasch's Sons Hyattsville, Md.						DATE MAR 4 1969					

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

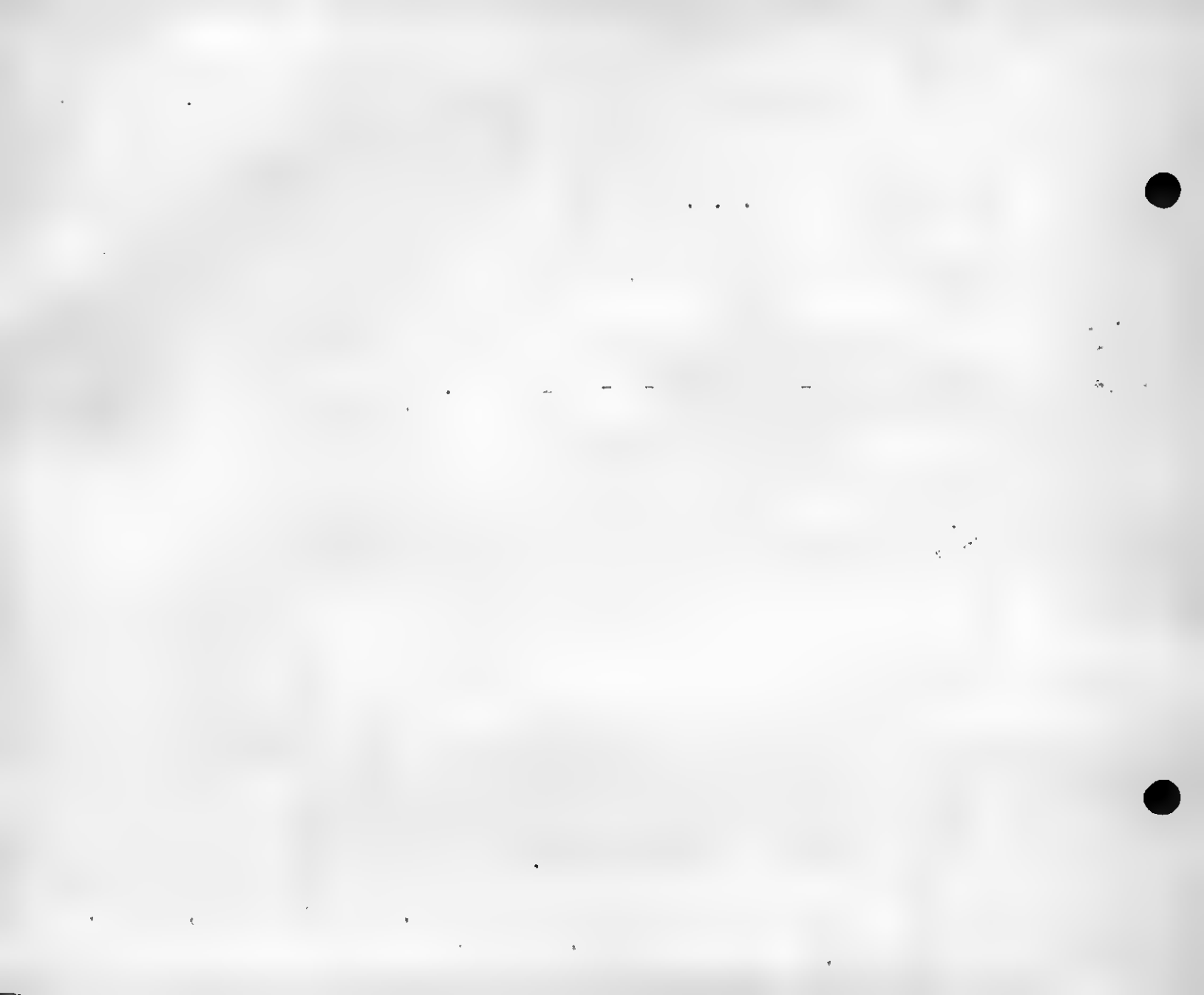
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR
Pamela Devorah Segroves						EST. <input type="checkbox"/> Month Day Year			3:15 a M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (n years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	
F	W	June 23, 1949	19 YRS					2 Day 21 Year 1969	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
South Carolina		USA				Prince George Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George Hosp						
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d STREET AND NUMBER
Md			Prince George						1226 Garner Ave.
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
James G. Segroves			Jacquelyn Carter						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS			
no						James G. Segroves, Father 126 Garner Ave., Waldorf, Md., 20601			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain 8150 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Trauma-auto accident DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 3:10 am 2 21 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver of car which hit bridge support.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) St Rt 5		21f. LOCATION Street or R.F.D. No TB		City or Town P. G.		County State Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 2-22-69
John Kehoe, M.D., Riverdale						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/25/69		Arlington National		Arlington, Virginia			
24. FUNERAL DIRECTOR				25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert E. Wilhelm Funeral Home 4308 Suitland Road, S.E., Washington, D. C. 20032				FEB 27 1969					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH MATED			2b HOUR
Eleanor Shaw						2-10-69 1911			50am
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Female	White	1-11-1885	84 YRS					2 10 69	11:50am
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
England		U.S.A.				Prince George's Md.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital				Housewife			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before death, give street address)		13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland		Prince George's New Carrollton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7609 Vicar Place			
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
George Hodgson			Elizabeth Butler						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
No			170-09-3201		Eliz. Lodwick (above address)				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure								hours	
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease								years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
John Kehoe MD		Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				2-10-69	
				ADDRESS (Street city town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		2/14/69		The Shady Lane Cem.		Chinchilla, Penna.			
24. FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Nalley's Funeral Home Inc.				FEB 17 1969		J. M. [Signature]			



02882

CERTIFICATE OF DEATH

02877

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Alfonso		S.		Small	2 - 13 - 69			1:45 PM	
3. SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	N		10/3/1904		64 YRS.		MONTHS DAYS		HOURS MIN.
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington, D. C.		USA				Prince Georges, Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Glenn Dale		Glenn Dale Hospital		retired		unknown			
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
				Washington, DC				1724 C St., N. E.	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost
Richard				Small	Josephine				Dorsey
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address			
no		579-01-2913		decedent					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombophlebitis, legs</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular accident (basilar artery thrombosis)</u> months Approximate interval between onset and death: <u>sudden</u> weeks									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus; severe decubitus ulcers</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>12/23/1969</u> , to <u>2/13/1969</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2/13/1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED			
Moe Weiss						2/13/69			
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS							
Moe Weiss, M. D.		Glenn Dale Hospital, Glenn Dale, Md.							
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		2/17/69		Lincoln Memorial Cemetery		Maryland			
24 FUNERAL DIRECTOR		DATE		25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
John J. Stewart		FEB 17 1969		DATE FEB 17 1969		R. A. F.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02878

FOR STATE HEALTH DEPT.

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH	Month	Day	Year	2b. HOUR
Minnie Smallwood					<input checked="" type="checkbox"/> 2	24	19	69	2:30 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years)	7. UNDER 1 YEAR	8. UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		Month	Day
F	W	7 June 1894	74 YRS	MONTHS	DAYS	2	24	19	69
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Virginia		USA				Prince George			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Rivendale		Leland Hosp		housewife		house			
13a. JSLA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. ASIDE CITY, JIM TS?		13e. STREET AND NUMBER	
Md.		Prince George		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		411 Main St. Apt 302	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Littleton				Akers	Medred				Shumate
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
no				Clem Blakemore		Savage Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									
4109 Heart failure									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Coronary artery occlusion									HRB.
DUE TO, OR AS A CONSEQUENCE OF									
(c) Arteriosclerotic heart disease									Yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY?	
2-23-69				Fracture of left humerus				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				6:30 P.M. 2 16 19 69		Home-Fell while running from burning bldg.			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John Kehoe, M.D., Rivendale				CHIEF MED. CAL. EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>		2-24-69	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		2/27/69		Unity Church Am		Pleasant Corner Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Donaldson Funeral Home		Laurel		DATE 5 1969		Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with funeral home's report. Page 5 may be retained for your files.

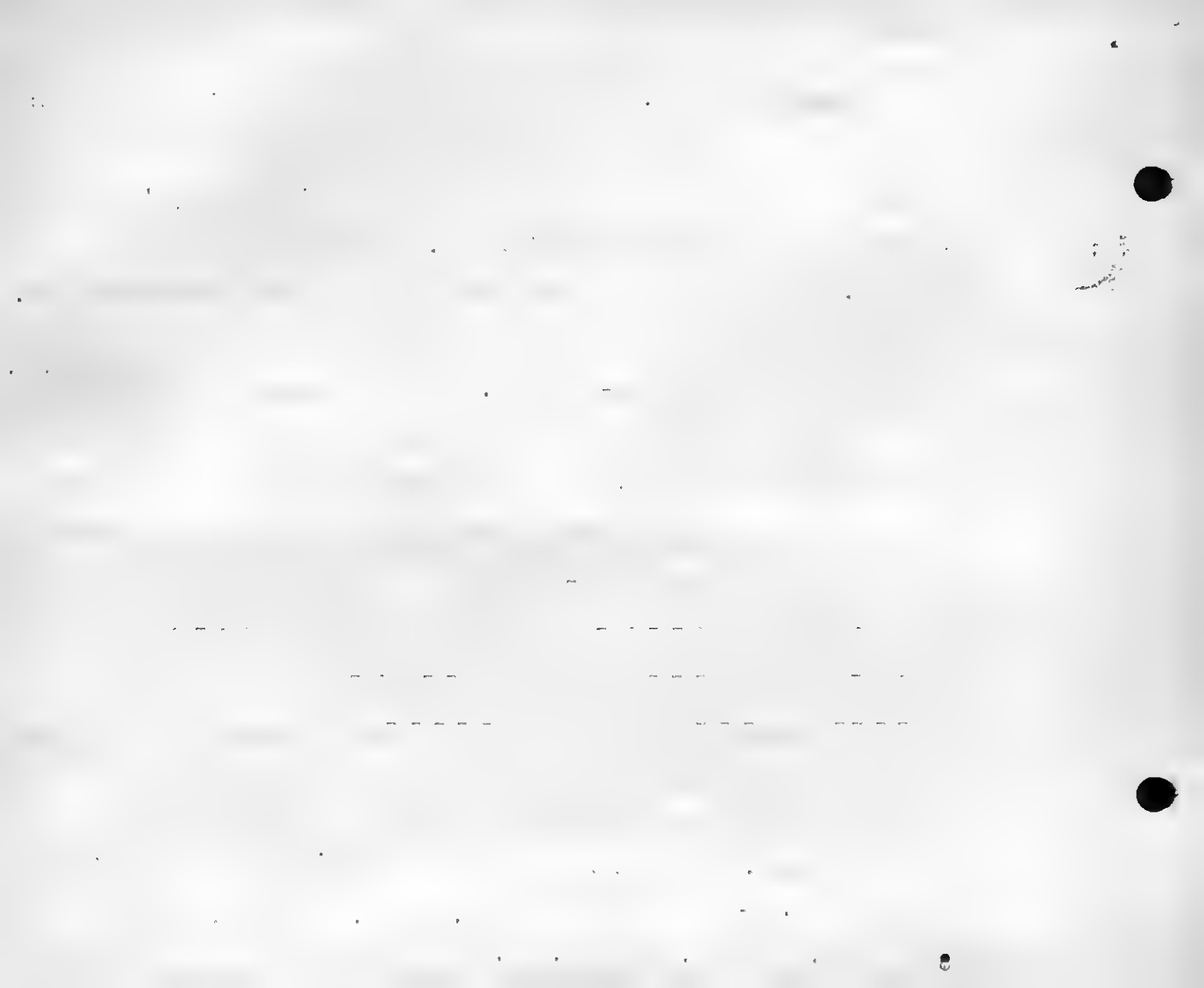
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Joseph			F. Soresi			2 Month 1 Day 69 Year			12:45 PM
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		7/30/82			86 YRS.		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Italy		USA				Prince George's Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Riverdale			Leland Memorial Hos.			Retired		Barber	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Md.			P G		Camp Springs		NO		6006 West Chester Ct.
14 FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Unknown				Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.		17 INFORMANT				
No			578-44-2104		Daughter of Mrs. Angelina Ingledue				
					Camp Springs, Md. 6006 Westchester Ct.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis Generalized</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 2 years 20 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Uremia for 2-4 weeks</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. B.TING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. -- -- -- 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION		Street or R.F. No		City or Town County State	
22a. I certify that (I) (we) attended the deceased from <u>May 22, 1955</u> to <u>February 1, 1969</u> , that (I) (we) last saw the deceased alive on <u>January 31, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE <u>Walcutt W. Gibson, M.D.</u>				22c. DATE SIGNED February 1, 1969		22d. PHYSICIAN'S NAME (Type) Walcutt W. Gibson, M.D.			
				22e. ADDRESS 4300 St. Barnabas Road Marlow Heights, Maryland 20031					
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb. 5-1969		Cedar Hill Cem. Crypt.		Suitland, Maryland			
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>				ADDRESS 1661-Gd. Hope RD. SE.DC		25a REC'D BY REGISTRAR FEB 4 1969		25b REGISTRAR'S SIGNATURE <u>Charles Jones</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1 DECEASED-NAME (Type or Print) First Middle Last Russell Garneil Spencer										2a DATE KNOWN OF DEATH ESTI MATED <input type="checkbox"/> Month Day Year 2-5-69 19:30am		2b HOUR
3 SEX Male	4 RACE Negro	5 DATE OF BIRTH 18 Aug. 1940	6 AGE (in years last birthday) 28 YRS	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year 2 5 69 1972 noon		2d HOUR		
7a BIRTHPLACE (State or foreign country) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's			Md			
10. CITY OR TOWN OF DEATH Cheverly			NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Prince George's Upper Marlboro			13c CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>		13d INSIDE CITY LIMITS?			13e. STREET AND NUMBER RFD Box 3398, Croom Road	
14 FATHER'S NAME First Middle Last Elmore L. Spencer				15 MOTHER'S MAIDEN NAME First Middle Last Marion Windsor								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT Mrs. M. Spencer - Above			ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Burns 100 per cent of body surface DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. 9:30am 2-5- 19 69			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Burned in house fire						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home			21f LOCATION Street or R.F.D. No same as #13			City or Town		County	State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe MD		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
						ADDRESS (Street, city, town, or county)		22b DATE SIGNED 2-6-69				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 2-8-69		23c NAME OF CEMETERY OR CREMATORY Brooks Church Cem.			23d LOCATION (City or Town) (County) (State) Willingham Pr. Geo. Md.				
24 FUNERAL DIRECTOR Martell Adams			ADDRESS Aguasco, Md.			25a REC'D BY REGISTRAR DATE FEB 11 1969		25b REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02886

CERTIFICATE OF DEATH

02881

1. DECEASED NAME (Type or print) First Middle Last Helen Spitler			2a. DATE OF DEATH Month Day Year Feb. 12, 1969			2b. HOUR 5:30 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11/1/92		6. AGE (in years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. General Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S.A. RESIDENCE (Where deceased lived, if institut an- Residence before admiss an) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER 8121 Powhatan Street	
14. FATHER'S NAME First Middle Last GEORGE PATRICK			15. MOTHER'S MAIDEN NAME First Middle Last A. HULL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO UNKNOWN			17. INFORMANT MRS MILDRED KRUGER Address SAME AS #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions if any which gave rise to immediate cause (a), stating the underlying cause last (b) CEREBRAL ARTERIO SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) INDEFINITE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 2-9-69 , 19 69 , to 2-12 , 19 69 , that (I) (we) last saw the deceased alive on 2-11-69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Roger B. Ingham				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2-12-69					
22d. PHYSICIAN'S NAME (Type) Dr. Roger Ingham				22e. ADDRESS 5701 85th AVE NEW CARROLLTON MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-15-1969		23c. NAME OF CEMETERY OR CREMATORY MORRISON CEM.				23d. LOCATION (City or Town) (County) (State) HENRY COUNTY, OHIO.			
24. FUNERAL DIRECTOR W. W. Chamberlin to Riverdale, Md.				ADDRESS		25a. REG. REGISTRAR FEB 20 1969		25b. REGISTRAR'S SIGNATURE			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02882

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year				2b HOUR			
Florence		Silvia		Sponseller				2-11-69 11 35am				35am			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c DATE PRONOUNCED DEAD Month Day Year				2d HOUR		
Female	White	3-24-1890		78 YRS					2 11 69 19 11 35am						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8		9 COUNTY OF DEATH									
Canada		U. S.				Prince George's		Md							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince George Hospital				HOUSEWIFE				HOME			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE				13b COUNTY				13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland				Prince George's				Greenbelt		YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 265			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME											
First Middle Last				First Middle Last											
ENOS				MARR				MARGARET				COSBY			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17. INFORMANT ADDRESS							
NO				373-07-6512				D4 GEORGIA SCHRAM SAME AS ABOVE							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Fracture of left hip - 12-12-68</u>															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 ALTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR AM PM 12-12-19 68				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fell at home							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home				21f LOCATION Street or RFD No City or Town County State same as #13							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				22b DATE SIGNED							
				John Kehoe MD Riverdale, Md.				2-12-69							
23a BURIAL, CREMATION, REMOVA. (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
Burial				2-15-69				LUTHERAN CEMETERY				DETROIT WAYNE MICH.			
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
F. GASCH'S SONS				HYATTSVILLE, MARYLAND				DATE FEB 14 1969							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR			
GEORGIA LOUISE STRONG						Feb. 28 1969		M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR			
Female		White		2-27-13		55 YRS		MONTHS DAYS HOURS M.N.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W. Va.		USA				Prince Georges		Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Adelphi			1901 Elton Road			housewife		own home			
13a USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13e STREET AND NUMBER				
Md.			P.G.		Hyatts.		1901 Elton Road		5432 Hamilton Avenue Dr.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
Wallace A. Myers, Sr.			Etta Thompson								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b SOCIAL SECURITY NO.			17 INFORMANT		Address			
No			215-52-0730			Robert M. Strong		10316 Inwood Avenue		Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Lung										6 months	
1621 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
			HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION			State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No			City or Town County		
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1968, to Feb. 1969, that (I) (we) .ast saw the deceased alive on Feb 16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED	
Israel Spector MD										2/23/69	
22d PHYSICIAN'S NAME (Type)						22e ADDRESS					
ISRAEL SPECTOR MD						911 Silver Spring Ave		Silver Spring Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)		
B. m. a.			2-26-1969		George Washington Cemetery		Hyattsville, Pr. Geos.		Md.		
24a FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REGISTRAR		25b REC'D BY REGISTRAR	
Warner E. Pumphrey, Inc.						Sil. Spr., Md.		FEB 28 1969			
8434 Georgia Avenue											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02889

02884

DECEASED NAME (Type or print)		First	Middle	Last	20. DATE OF DEATH		2b HOUR	
Charles		Lee	Suit	111	2-12-69 Month Day Year		10:30p M	
3. SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS HOURS MIN	
Male	White		11-12-25		43 YRS.			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Texas	USA				Prince George Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale		Eugene Leland Memorial		Salesman		Gulf Oil Corp.		
13a. USLA. RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		Prince George		Laurel		YES		200 Ft. Meade Dr.
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
Charles L.		Vinnie L. Dabney						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT				
Yes		WWII		Patient and Medical Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>								INSTANT.
4109 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
		HOUR AM Month Day Year P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
White <input type="checkbox"/> Not while at work <input type="checkbox"/>								
22a. I certify that (I) (this hospital) attended the deceased from <u>10 FEB, 1969</u> , to <u>12 FEB, 1969</u> , that (I) (we) lost the deceased alive on <u>12 FEB 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
C. J. Houmann		13 FEB 1969						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
C. J. HOUMANN M.D.		RIVERDALE MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		2/15/69		Hill Crest Cemetery		Temple, Texas		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Laurel Funeral Home of Howard M. Fleck		550 Washington Blvd. Laurel, Md. 20810		FEB 19 1969				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form 4-PM. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										02883			
1. DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR		
James William Swecker			11						Month Day Year		5:00 a.m.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS	8 UNDER 24 HRS DAYS	9 UNDER 24 HRS HOURS	10 UNDER 24 HRS MIN.	2c. DATE PRONOUNCED DEAD		2d. HOUR			
M	W	4 July 1967	19 months	7				Month Day Year		19 68 35 a.m.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Md.		U.S.A.				Prince George		Md					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly			Hospital Prince George			none			none				
13a. USUAL RESIDENCE (Where deceased was, if not at residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?				
Md.			Prince George			District Heights			NO <input type="checkbox"/>				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.				
James William Swecker			Donna			no			none				
17. INFORMANT			18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____			19. DATE OF OPERATION			20. AUTOPSY?				
Donna T. Swecker			Hydrocephalus			Jan 1969			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
Same as # 13			DUE TO, OR AS A CONSEQUENCE OF			Revision of shut from brain to heart							
21a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town				
									County				
									State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			22b. DATE SIGNED			23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE				
John Kehoe, M.D., Riverdale			2-16-69			Burial			2/19/69				
EXAMINER'S NAME (Type)			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			23e. COUNTY				
			Cedar Lawn			Roanoke			Roanoke Va.				
24. FUNERAL DIRECTOR			25. REGISTRAR'S SIGNATURE			26. DATE			27. REGISTRAR'S SIGNATURE				
Francis Gasch's Sons Hyattsville, Md.			FEB 19 1969										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		Month	Day	Year	2b. HOUR
RUTH				Sweetser	2		8	1969	12:00 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FE.	WHITE		5/14/1888		60		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
ILLINOIS	UNITED STATES				PRINCE GEORGES Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Adelphi, Md.		MORRIS CARE Adelphi, Md.		RT HOME						
13a. USUAL RESIDENCE (Where deceased lived, if institution, on. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
D.C.					WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3060 GARRISON ST. N.E.	
14. FATHER'S NAME			15. MOTHER'S M A DEN NAME							
First Middle Last			First Middle Last							
ROBERT			GREGORY			ADDIE HUBBARD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT					
			050-22-54253		4108 RES EMPORT ST. GENEVIEVE GARDNER, MD. MRS. JOSEPH W. CLIFFORD, PARKSTER					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure										24 hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis										10 yr
(c) Diabetes mellitus										5 yr
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Cerebrovascular disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from JAN 16, 1969, to Feb 8, 1969, that (I) (we) last saw the deceased alive on Feb 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED		
Ronald W. Bare, M.D.										
22d. PHYSICIAN NAME (Type)					22e. ADDRESS					
RONALD W. BARE, M.D.					10401 OLD GEORGETOWN Rd BETHESDA, MD					
23a. BURIAL (Cremation, Removal) (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2-10-1969		Rock Creek Cemetery		Washington, D.C.				
24. FUNERAL DIRECTOR					25a. REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016					DATE FEB 13 1969		Ronald W. Bare			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
30M REV.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 02892 CERTIFICATE OF DEATH 02887 </div>									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M
JOHN R. SYME						FEB. 9 1969			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
M		W		March 12, 1920		48 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNSYLVANIA		USA				PRINCE GEORGE Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
LAUREL		1207 SNOWDEN PLACE		ACQUISITION SPECIALIST		U.S. GOVT			
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		PRINCE GEORGE		LAUREL		YES		1207 SNOWDEN PLACE	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
JOHN R. SYME						PEARL SMITH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
YES			169-05 8645			JANET SYME - ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , to <u>Feb 9</u> , 1969, that (I) (we) lost saw the deceased alive on <u>Feb 9</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert E. Wingfield</u>				DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		22c. DATE SIGNED			
ROBERT E. WINGFIELD				Laurel, Maryland		Feb 12, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		2-13-69		BALT. NATL. CEM.		BALTIMORE		MD	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
DONALDSON FUNERAL HOME, LAUREL, MD				FEB 15 1969					

MEDICAL CERTIFICATION

02889

CERTIFICATE OF DEATH

02889

1. DECEASED-NAME (Type or print) <u>William</u> <u>H.</u> <u>TANNER</u>		2a. DATE OF DEATH <u>2</u> Month <u>15</u> Day <u>69</u> Year		2b. HOUR <u>11:45</u> M
3 SEX <u>m</u>	4 RACE <u>W</u>	5. DATE OF BIRTH <u>Feb 6, 1915</u>	6 AGE (In years last birthday) <u>54</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <u>FARRELL Pennsy/Varia</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Prince Georges</u> Md	
10. CITY OR TOWN OF DEATH <u>Lanham</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>7724 EMERSON Rd</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>AUTO MECHANIC</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>JACK BLANK POSTER</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <u>MD</u>	13b. COUNTY <u>PG</u>	13c. CITY OR TOWN <u>Lanham</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>7724 Emerson Rd</u>
14. FATHER'S NAME First <u>MORAN</u> Middle <u>OLIVER</u> Last <u>TANNER</u>	15. MOTHER'S MAIDEN NAME First <u>Bertha</u> Middle <u>FERN</u> Last <u>JENKINS</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>yes</u>	16b. SOCIAL SECURITY NO. <u>1948-1950</u>	17. INFORMANT <u>MRS MARGARET L. TANNER</u>	Address <u>SAME AS #13</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>400.2</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) <u>Malignant Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Pyelo-nephritis</u>				APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <u>5 hours</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)		
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No. City or Town County State		
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>July</u> , 19 <u>64</u> , to <u>Feb.</u> , 19 <u>69</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Feb. 15, 1969</u> , and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.				
22b. SIGNATURE <u>FRANCHI MD</u>	DEGREE <u>MD</u>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <u>2-25-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>RUFRANCHI</u>	22e. ADDRESS <u>7729 Finn's Lane Lanham Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>3-1-1969</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>COLMAR MANOR, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO., RIVERDALE, MD</u>	25a. REC'D BY REGISTRAR <u>DATE MAR 3 1969</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02889	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b HOUR		
Bradford Luckett Taylor						2-17-69 19 1:07pm					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR		
Male	White	12-8-1906	62 YRS	MONTHS	DAYS	HOURS	MIN	2 17 Day 69 Year	19 1:07pm M		
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md		
Miss		U.S.					Prince George's				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Book Binder			U.S. PRINTING		
13a USUAL RESIDENCE (Where deceased lived, if institution Res. dence before address on) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince George's			Landover			6910 Allison Street # C-3		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
MARION TAYLOR			FRANCES LUCKETT								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or Unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
No			577 60 6350			BRADFORD L. TAYLOR			6310 BARRS LANE LANHAM, M.D.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure										hours	
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										over 5 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Diabetes mellitus - years											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOURS A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			2-18-69		
John Kehoe MD Riverdale, Md.											
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL (Specify)		2-21-1969		FORT LINCOLN CEM		COLMAR MANOR, MARYLAND					
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
W. W. CHAMBERS Co. RIVERDALE, MD						FEB 26 1969			John Kehoe		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV.

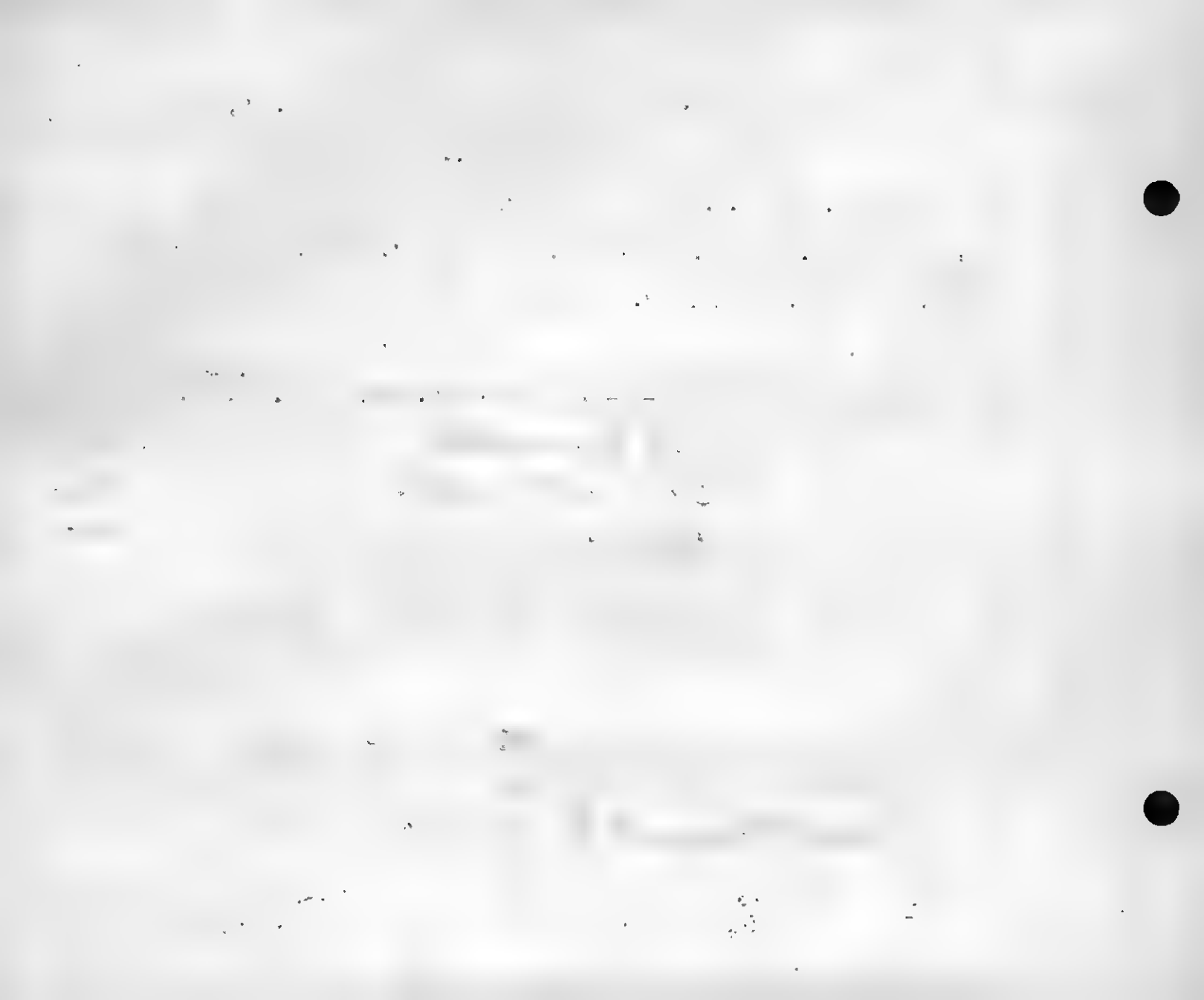
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02895

02891

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Elsie Pauline Taylor			2a. DATE OF DEATH Month Feb. Day 19, Year 1969			2b. HOUR M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 22, 1890		6. AGE (In years last birthday) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.					
10. CITY OR TOWN OF DEATH Riverdale, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) E. Leland Mem.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE MD		13b. COUNTY Howard Md.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 414 N. Laurel Rd			
14. FATHER'S NAME First Thomas W. Middle Brown Last			15. MOTHER'S MAIDEN NAME First Albina Middle Kenziz Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 219-54-3358		17. INFORMANT Walter C. Taylor		414 N. Laurel Rd, Laurel, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute Myocarditis 402X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wk 20 yr 21 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4/26 , 19 48 , to 2/19 , 19 69 , that (I) (we) last saw the deceased alive on 1/15 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert S. McCenedy, M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) ROBERT S. MCCENEDY, M. D. 402 MAIN ST. LAUREL, MARYLAND 20610				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Feb. 22, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Paul's		23d. LOCATION (City or Town) (County) (State) Laurel - Prince George - MD					
24. FUNERAL DIRECTOR Arnaldorn J. H. Daniel, MD				ADDRESS		25a. RECEIVED BY REG. SEAR FEB 28 1969		25b. REGISTRAR'S SIGNATURE [Signature]			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02896										02897																			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
1 DECEASED NAME (Type or Print) ^{First} Lawrence ^{Middle} Edward ^{Last} Taylor										2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 2 Day 28 Year 69 ^{2b HOUR} 9:50 ^M																			
3 SEX M		4 RACE W		5 DATE OF BIRTH 5 Nov 1925		6 AGE (In years last birthday) 43 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month 2 Day 28 Year 69					2d HOUR 9:50 ^M												
7a BIRTHPLACE (State or foreign country) N. Carolina				7b CITIZEN OF WHAT COUNTRY? U.S.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Prince George ^{Md}																	
10. CITY OR TOWN OF DEATH Camp Springs				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AAFB Hosp AFB								12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired				12b KIND OF BUSINESS OR INDUSTRY U.S. Navy													
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.										13b. COUNTY Prince George										13c STREET AND NUMBER 6201 Hope Drive									
14. FATHER'S NAME ^{First} Lonnie ^{Middle} Edward ^{Last} Taylor										15 MOTHER'S MAIDEN NAME ^{First} Jennie ^{Middle} Hawkins ^{Last}																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes U.S. Navy										16b SOCIAL SECURITY NO 239-30-4566					17 INFORMANT Wife Jeannett E Taylor					ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock																		Minutes											
DUE TO, OR AS A CONSEQUENCE OF Hemorrhage																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Laceration of liver																		5 days											
(b) DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a DATE OF OPERATION 2-23-69										19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Laceration of Liver										20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>										21b TIME OF INJURY Month, Day, Year 6 23 69 pm P.M.					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) St Rt 5 nr Old Alexander Ferry Rd...														
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street					21f. LOCATION Street or RFD No City or Town County State Driver of car involved in collision																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										22b. DATE SIGNED 3-1-69									
EXAMINER'S NAME (Type)										ADDRESS (Street, city, town, or county)																			
23a BURIAL, CREMATION, or DISPOSAL Burial					23b DATE Mar. 4-69					23c NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.					23d. LOCATION (City or Town) (County) (State) Arlington, Virginia														
24 FUNERAL DIRECTOR Simmons Bros.										ADDRESS Wash										25 REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
1661- Gd. Hope Rd. SE. DC.										DATE MAR 4 1969																			

1

2

3

cleared with Dr. Kehoe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02897

02892

1 DECEASED-NAME (Type or print) Howard		First Howard		Middle C.		Last TEMPLETON		2a. DATE OF DEATH Feb. Month 4 Day 1969 Year		2b. HOUR 4 P.M.	
3 SEX M.		4 RACE W		5. DATE OF BIRTH June 13, 1911				6. AGE (in years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) N C		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH College Heights Estates				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3914 Commander Drive				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Roof contractor		12b. KIND OF BUSINESS OR INDUSTRY owner	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution) STATE Md				13b. COUNTY Pro Geo Co		13c. CITY OR TOWN College Hts		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 3914 Commander Drive	
14. FATHER'S NAME George G Templeton				First George G		Middle Templeton		15. MOTHER'S MAIDEN NAME Roxie Seckler		First Roxie Middle Seckler Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No. (Yes, no, or unknown)				16b. SOCIAL SECURITY NO 217 09 4045		17. INFORMANT Mollie V Templeton		Address College Heights Estates			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 										10 min. 3 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (1) (this hospital) attended the deceased from Feb. 27, 1969 to Feb 4, 1969 , that (1) (we) last saw the deceased alive on Jan 27, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death											
22b. SIGNATURE R.D. Bauer, M.D.		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2-4-69					
22d. PHYSICIAN'S NAME (Type) R. D. Bauer, M.D.		22e. ADDRESS 2513 Buck Lodge Rd. Adelphi, P.G. Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Feb 7, 1969		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory		23d. LOCATION (City or Town) Colmar Manor Pro Geo (County) Md. (State)					
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR Feb 8 1969 DATE		25b. REGISTRAR'S SIGNATURE [Signature]					



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VR 1515
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) John J Thomas			2a DATE OF DEATH Month 2 Day 20 Year 69			2b HOUR 9:20 A M			
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH 4/8/82		6 AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) md.		7b CITIZEN OF WHAT COUNTRY? U.S. A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Geo. Md.			
10 CITY OR TOWN OF DEATH Clinton		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PINE VIEW GARDENS		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SAINTLY DEPT		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution) STATE MD Washington, DC		13b COUNTY 1		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 11815 OLD FORT Rd. S.E.	
14 FATHER'S NAME First Joseph Middle Thomas Last Thomas			15 MOTHER'S MAIDEN NAME First Melvinia Middle Corbet Last Corbet						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Collapse 4122 DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 min 25 min	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pneumonia lobar, left lower; Malnutrition									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from 2/8 , 19 67 , to 2/20 , 19 69 , that (I) (we) last saw the deceased alive on 2/19 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Archie R. Lapin				22c DATE SIGNED 2/20/69		22d PHYSICIAN'S NAME (Type) A. R. LAPIN, MD			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 2/25/69		23c NAME OF CEMETERY OR CREMATORY Grace Methodist Church		23d LOCATION (City or Town) (County) (State) Chapel Hill, Md.			
24 FUNERAL DIRECTOR KIRBERT G. MASON F.H.				25 REC'D BY REGISTRAR NICHOLS HUE		25b REGISTRAR'S SIGNATURE Charles Judge			
ADDRESS 2500 NICHOLS HUE				DATE FEB 25 1969					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02599

02891

1. DECEASED NAME (Type or print) JOHN First ROY Middle THOMAS Last			2a. DATE OF DEATH 2 Month 28 Day 69 Year			2b. HOUR 3 AM					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6.29.91		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES			Md		
10. CITY OR TOWN OF DEATH FORESTVILLE MD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) REGENT NURSING CENTER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY US Gov't		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WASH DC COUNTY DC			13c. CITY OR TOWN WASHINGTON		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 213 WALNUT NW				
14. FATHER'S NAME First John Middle L. Last THOMAS			15. MOTHER'S MAIDEN NAME First JULIA Middle BATEMAN Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. —		17. INFORMANT DONALD W. THOMAS			Address 648 LAMBETH DR TEMPLE HILLS MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) LEFT LOWER LOBE PNEUMONIA 45.51 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ADVANCED ARTERIOSCLEROTIC PARKINSON'S DISEASE											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-15- 19 69 to 2-28- 19 69 , that (I) (we) last saw the deceased alive on 2-27- 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Oliver B. Bond						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2.28.69			
22d. PHYSICIAN'S NAME (Type) OLIVER B. BOND						22e. ADDRESS 7420 MARLBORO PIKE FORESTVILLE MD 20028					
23a. BURIAL, CREMATION, REMOVAL (Specify) SERIAL			23b. DATE 3-3-69		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.			23d. LOCATION (City or Town) (County) (State) SUITLAND MD			
24. FUNERAL DIRECTOR ROBERT E. WILHELM						ADDRESS 4308 SUITLAND RD SUITLAND MD		24b. REC'D BY REGISTRAR DATE MAR 7 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

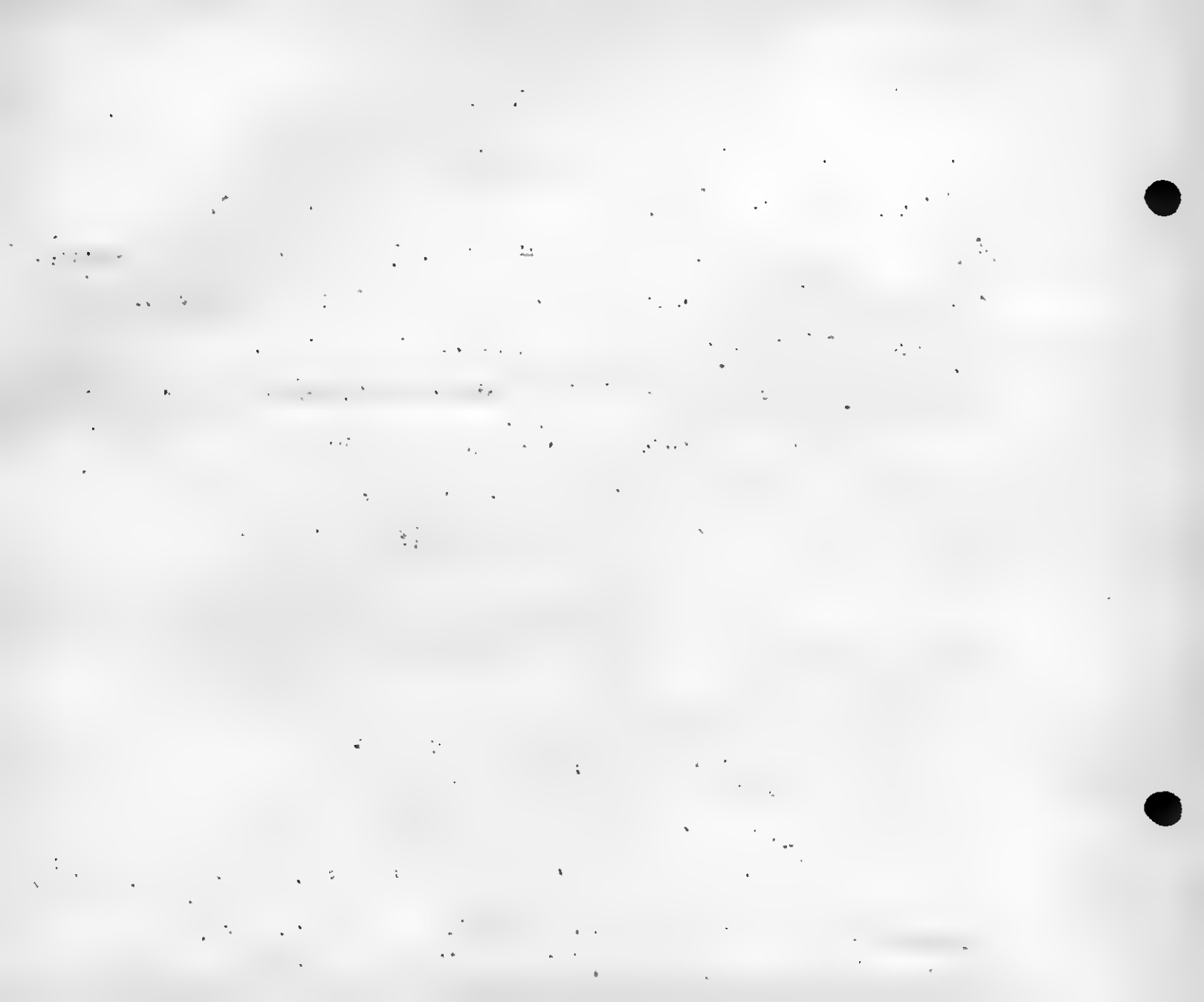
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02900

02895

1 DECEASED NAME (Type or print) <u>Frank</u> First Middle Last			2a. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>69</u>			2b. HOUR <u>9:20 P.M.</u>	
3. SEX <u>MALE</u>		4 RACE <u>WHITE</u>		5. DATE OF BIRTH <u>7-1 1892</u>		6. AGE (In years last birthday) <u>76</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George's</u> Md.	
10. CITY OR TOWN OF DEATH <u>ADELPHI MD</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>PAINT BRANCH N. Home</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Post Office</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>1303 MERRIMAC AVE</u> <u>ADLPHI</u> 13b. COUNTY <u>M.D.</u>		13c. CITY OR TOWN <u>M.D.</u>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <u>Merrimac Drive</u> <u>1303</u>	
4. FATHER'S NAME First Middle Last <u>JAMES TIERNAN</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>ROSE KILKENNY</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16b. SOCIAL SECURITY NO. <u>055-32-245</u>		17. INFORMANT <u>Frank Tiernan, Jr.</u> Address <u>9119 5th St. Lanham, Md.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute gastric hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF <u>ruptured esophageal varix</u> DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerotic heart disease</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>10-23, 1968</u> , to <u>2-19, 1969</u> , that (I) (we) last saw the deceased alive on <u>2-18, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>R.D. Bauer</u>		DEGREE <u>M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2-19-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>R.D. Bauer</u>		22e. ADDRESS <u>2513 Brookledge Rd. Adelphi 199-Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-24-1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Raymond Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Bronx, New York</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02901

02896

1. DECEASED-NAME (Type or print) First Middle Last GEORGE P. TIMPE			2a. DATE OF DEATH Month 2 Day 26 Year 69		2b. HOUR 2:55 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 8-4-1973		6. AGE (In years last birthday) 96 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) GERMANY	7b. CITIZEN OF WHAT COUNTRY? GERMANY	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH PRINCE GEORGE'S Md.		
10. CITY OR TOWN OF DEATH HYATTSVILLE	11. NAME OF HOSPITAL OR INSTITUTION ON (If not in hospital give street address) 4922 LASHILLE RD.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PRIEST	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived admission) STATE D.C.	13b. COUNTY WASHINGTON	13c. CITY OR TOWN WASH.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3415 12th St. N.E.	
14. FATHER'S NAME First Middle Last UNKNOWN JOHANN FRANZ TIMPE		15. MOTHER'S M A DEN NAME First Middle Last UNKNOWN BERTHA HITSCHER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 220-54-0175	17. INFORMANT Address SR. CHRISTINE 4922 LASHILLE RD.		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GENERAL VISCERAL FAILURE</u> 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC CARDIO-CIRCULATORY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 1950, to 2/26/69, 1969, that (I) (we) last saw the deceased alive on 2/26/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE F.W. Schneider		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2/26/69	
22d. PHYSICIAN'S NAME (Type) F.W. SCHNEIDER		22e. ADDRESS 201-8 ST N.E. D.C.			
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE 4 MAR 1969		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	
23d. LOCATION (City or Town) WASHINGTON DC		23e. COUNTY WASHINGTON DC		23f. STATE DC	
24. FUNERAL DIRECTOR RINDO FUNERAL HOME INC. WASHINGTON DC 20012		25a. REC'D BY REGISTRAR DATE MAR 4 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
John			W. Travers			February 1, 1969			5:40A ^M
3 SEX	4 RACE		5 DATE OF BIRTH			6. AGE (n years first birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Male	White		4/1/01			67 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		USA				Prince George's Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George's Gen. Hosp.			Carpenter			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13e. STREET AND NUMBER	
Maryland			Prince George's			Cottage City		40018 Parkwood Ave.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John L. Travers			Isabell Maria Peverill						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			
Yes			WW II			John W. Travers, Jr. - Son Arlington, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Rt. Lung Carcinoma with Metastasis to Brain</u>									
1621 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) _____ DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State				
					1 69				
22a. I certify that (H) (this hospital) attended the deceased from <u>12/1</u> , 19 <u>68</u> , to <u>February</u> , 19 <u>69</u> , that (H) (we) last saw the deceased alive on <u>Feb. 1</u> , 19 <u>69</u> , and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
<u>Joselito Magday, M.D.</u>					Feb. 1, 1969				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Joselito Magday, M.D.					Prince George's General Hospital, Cheverly Md.				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb. 5, 1969		Columbia Gardens Cem.		Arlington, Virginia			
24. FUNERAL DIRECTOR <u>C. M. Farnell</u>					25a. REC'D BY REGISTRAR <u>FEB 5 1969</u>				
<u>Murphy Funeral Home, P.O. Box 1, Va.</u>					REGISTRAR'S SIGNATURE <u>George</u>				

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

Approved by **MARYLAND CORONER OSCAR MANN M.D.**

Item 13eF Lm410 3/14/69 kk										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
Item 13eF Lm410 3/14/69 kk										022903																			
1 DECEASED-NAME (Type or print)										2a DATE OF DEATH																			
First Middle Last										Month Day Year																			
Anthony NMI Turek										2 7 69																			
3 SEX										4 RACE																			
Male										White																			
5. DATE OF BIRTH										6 AGE (In years last birthday)																			
1/14/1886										83 YRS.																			
7a BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?																			
Poland										USA																			
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																			
Prince Georges										Md																			
1d. CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)																			
Cheverly										Prince Georges Gen.																			
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b KIND OF BUSINESS OR INDUSTRY																			
Retired										Steel Work																			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE										13b COUNTY																			
Md.										Prince Georges																			
14 FATHER'S NAME First Middle Last										15 MOTHER'S MAIDEN NAME First Middle Last																			
Unknown										Mary Wrobel																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b SOCIAL SECURITY NO.																			
										201-07-0942																			
17 INFORMANT										Address																			
Stanley A. Turek										Same as 13a,b,e																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY.										30 min																			
IMMEDIATE CAUSE (a) acute coronary occlusion																													
4177																													
DUE TO, OR AS A CONSEQUENCE OF										years																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										years																			
(b) arteriosclerotic heart disease																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c) generalized arteriosclerosis																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																													
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a ACCIDENT WAS UNDERLYING					21b TIME OF INJURY					21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																			
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)					HOUR A.M. Month Day Year																								
					P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work																													
22a. I certify that (I) (this hospital) attended the deceased from April 1967 to Present, 1968, that (I) (we) last saw the deceased alive on 10-24-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b SIGNATURE										DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c DATE SIGNED									
Oscar Mann M.D.																				2/8/69									
22d PHYSICIAN'S NAME (Type)										22e ADDRESS																			
Oscar Mann M.D.										2141 K St. N.W. Washington, D.C.																			
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE					23c NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					2/10/69					Holy Name Cem.					Monessen, Pa.														
24 FUNERAL DIRECTOR										25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE									
Lee Funeral Home										Washington, D.C.										FEB 11 1969									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02904

02899

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M	
Gilmore		Frederick	Turney		Feb 27, 1969				
3. SEX male		4 RACE white		5 DATE OF BIRTH May 11, 1902		6 AGE (In years last birthday) 66		FUNDOR YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pro George's		Md	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pro George Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired carpenter		12b KIND OF BUSINESS OR INDUSTRY construction			
13a USCA. RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b COUNTY Pro Geo		13c CITY OR TOWN Lanham		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7709 Cross street	
14. FATHER'S NAME First Middle Last Benjamin Turney		15. MOTHER'S MAIDEN NAME First Middle Last Tora O Turney		Address Lanham, Md.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO (If yes give war or dates of service) 579 03 2868		17 INFORMANT Tora O Turney		Address Lanham, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (b) Chronic Pulmonary (obstructive) Emphysema 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (d) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years 1 month.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertensive + Atherosclerotic Heart Disease.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 1963, to Feb. 27, 1969, that (I) (we) last saw the deceased alive on Dec. 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. Frederick Barr MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3-1-69			
22d. PHYSICIAN'S NAME (Type) J. Frederick BARR, MD		22e ADDRESS 4500 College Avenue, College Park, Md.							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE March 3, 1969		23c NAME OF CEMETERY OR CREMATORY Mt Lincoln Cemetery		23d LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		ADDRESS		25a REC'D BY REGISTRAR MAR 4 1969		25b REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

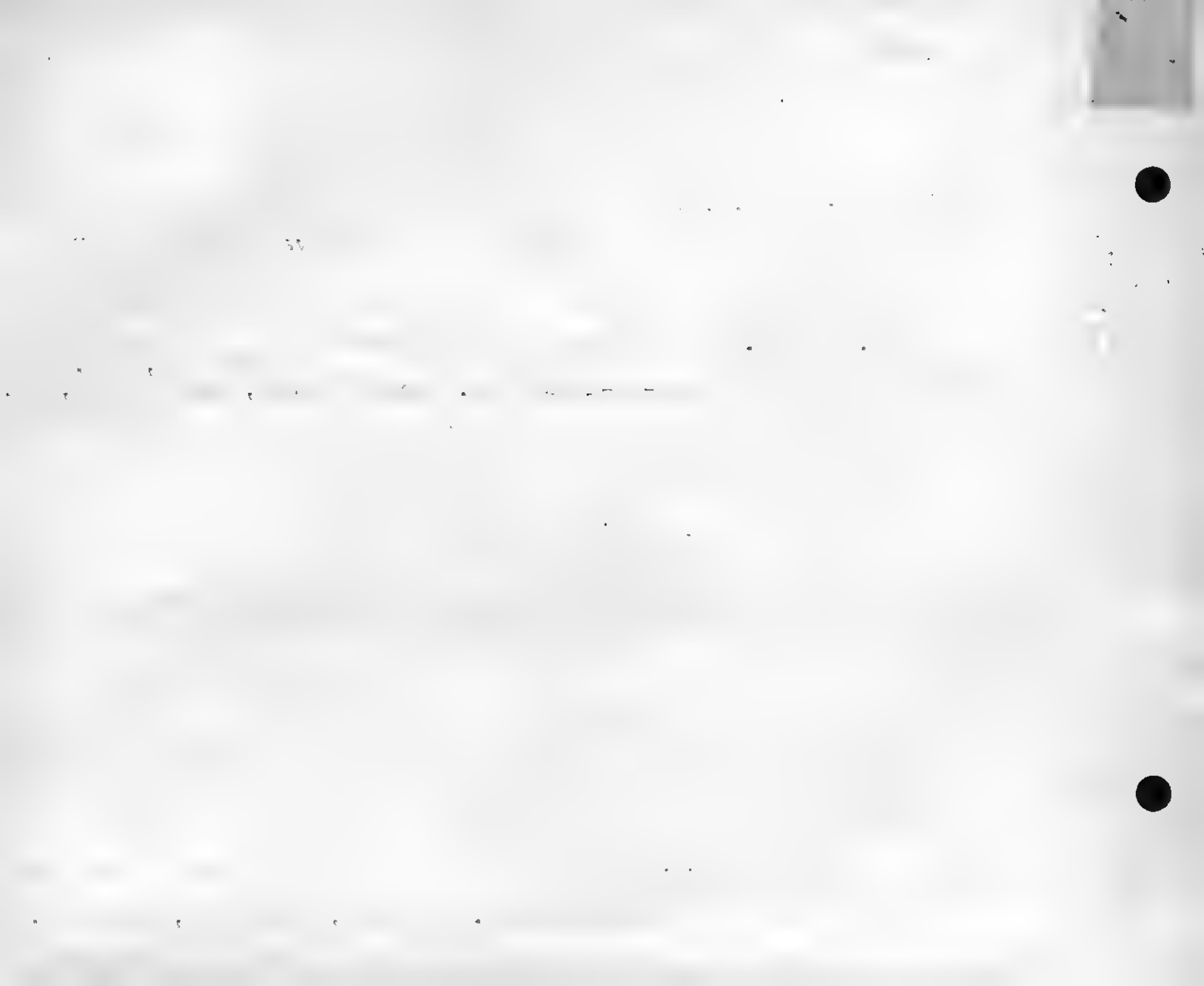
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove coroner papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02905

02900

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) James F. Vinson			2a. DATE OF DEATH 2/14/69 Month Day Year			2b. HOUR 3:30 M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH 06/12/15		6. AGE (in years last birthday) 53 YRS.	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Not Available		12b. KIND OF BUSINESS OR INDUSTRY ***	
13a. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last J. F. Vinson		15. MOTHER'S MAIDEN NAME First Middle Last Bessie Ellis		16. SOCIAL SECURITY NO 244-22-1043			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		17b. SOCIAL SECURITY NO ***		17. INFORMANT Mrs. Beckie Vinson, Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Thrombotic Occlusion, Left Descending Branch DUE TO, OR AS A CONSEQUENCE OF (b) Severe Stenosing Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) #2. Multiple Myeloma.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12-15 , 19 68 , to 2-14 , 19 69 , that (I) (we) lost saw the deceased alive on 2-15 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (d did not) view the body after death.							
22b. SIGNATURE Aaron Deitz				22c. DATE SIGNED 2/14/69			
22d. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.				22e. ADDRESS Prince George's Plaza Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-14-69		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Cemetery, Goldsboro, Wayne Co. NC		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR R.A. PUMAREY 7557 WISC. AVE. BETHESDA, Md 20014				25a. REC'D BY REGISTRAR 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Henry J. Wagner						2/28/69			8:00 A
3 SEX Male		4. RACE White		5. DATE OF BIRTH 08/06/01		6 AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) WASH DC		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Prince George's County Md.			
10 CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Prince George's		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY Teacher			
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Maryland		13b COUNTY Prince Geo.		13c CITY OR TOWN Landover		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2504 Columbia Avenue	
14 FATHER'S NAME First Middle Last John Wagner			15 MOTHER'S MAIDEN NAME First Middle Last Catherine M. Pfender						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) No		17. INFORMANT Margaret M. Clansman		Address 2504 Columbia Ave Landover Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diffuse Carcinomatosis, Primary Type not determined</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Broncho-Pneumonia, Left Lower Lobe.</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a I certify that (I) (this hospital) attended the deceased from <u>Feb 13, 1969</u> , to <u>Feb 28, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb 27, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas G. Maloney MD					ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED Feb 28, 1969		
22d. PHYSICIAN'S NAME (Type) Thomas G. Maloney, M.D.					22e ADDRESS 4814 71st Ave., Landover Hills, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-3-69		23c NAME OF CEMETERY OR CREMATORY Cedar Hill		23a LOCATION (City or Town) (County) (State) Suitland Md			
24 FUNERAL DIRECTOR Robert E. Welches, Funeral Home		ADDRESS 4308 Suitland Rd Suitland Md		25a RECEIVED BY REGISTRAR MAR 7 1969		25b REGISTRAR'S SIGNATURE Charles Judge			

02907

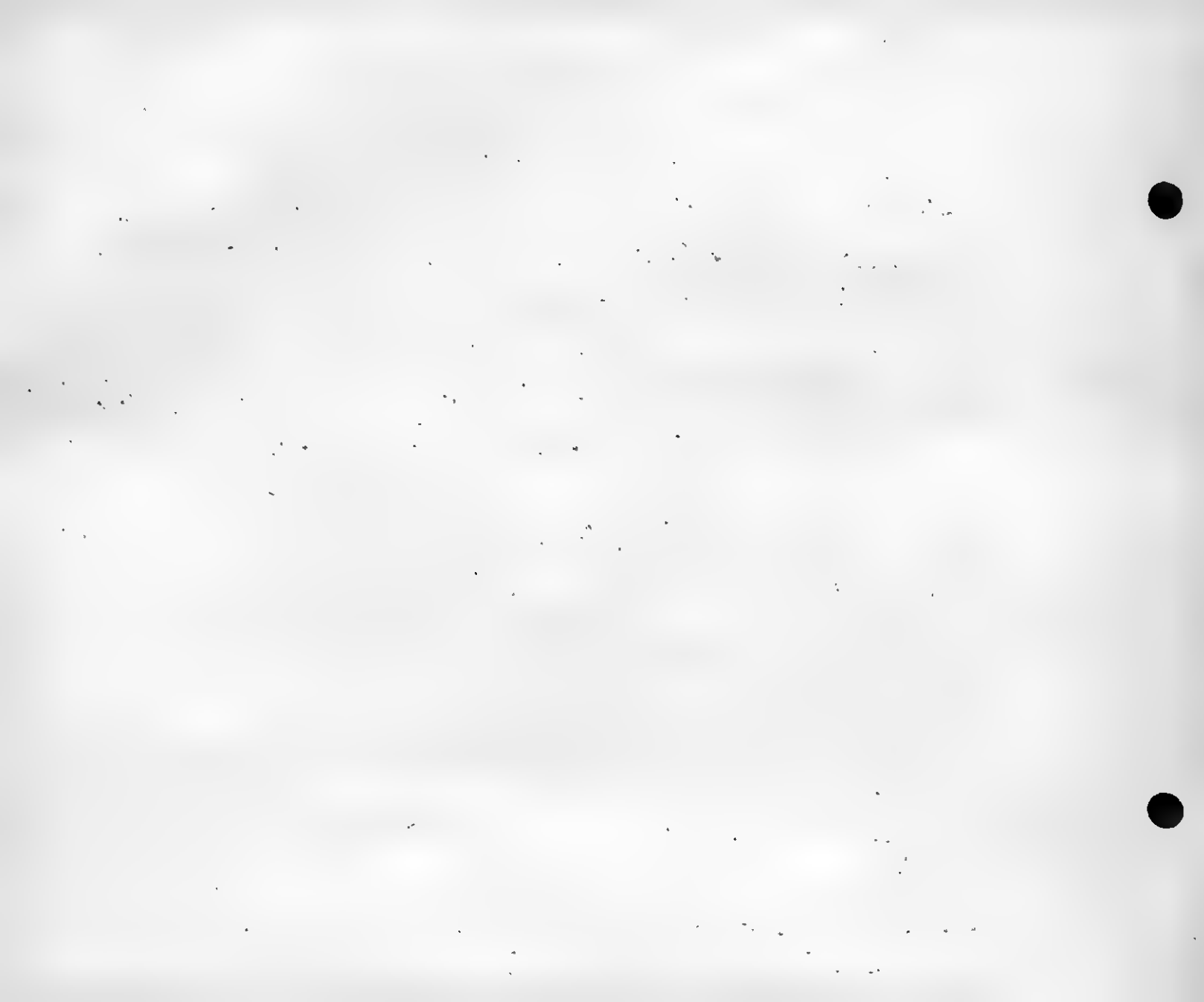
CERTIFICATE OF DEATH

02902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) EDWARD		First K.	Middle WALTERS	2a DATE OF DEATH Month Feb Day 26 Year 1969	2b HOUR M
3. SEX M	4 RACE W	5. DATE OF BIRTH Oct 14, 1908		6 AGE (In years last birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George Md	
10 CITY OR TOWN OF DEATH Riversdale		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Edward Memorial Hosp		12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) amusement operator	
13a U.S. RESIDENCE (Where deceased lived, if institut one Residence before admission) STATE md		13b COUNTY Prince George	13c CITY OR TOWN Laurel	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER Box 155 Rt 2
14 FATHER'S NAME First Conrad		Middle Walters	15 MOTHER'S MAIDEN NAME First Loretta V Middle Tilley Last Tilley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b SOCIAL SECURITY NO 163 05 4335	17 INFORMANT Madge Zimple Silver Address 15611 Ridgeway Dr Laurel Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Gen. Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 d 5 yrs - 7 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Head Cancer Throat					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/6 , 19 48 , to 12/4/68 , 19 68 , that (I) (we) lost saw the deceased alive on 2/1/69 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J M Warren		DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 2-28-69		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
23d. LOCATION (City or Town) (County) (State) Burtonsville Md.					
24. FUNERAL DIRECTOR Sanadchan Funeral Home, Laurel, Md.		25a REC'D BY REGISTRAR DATE MAR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



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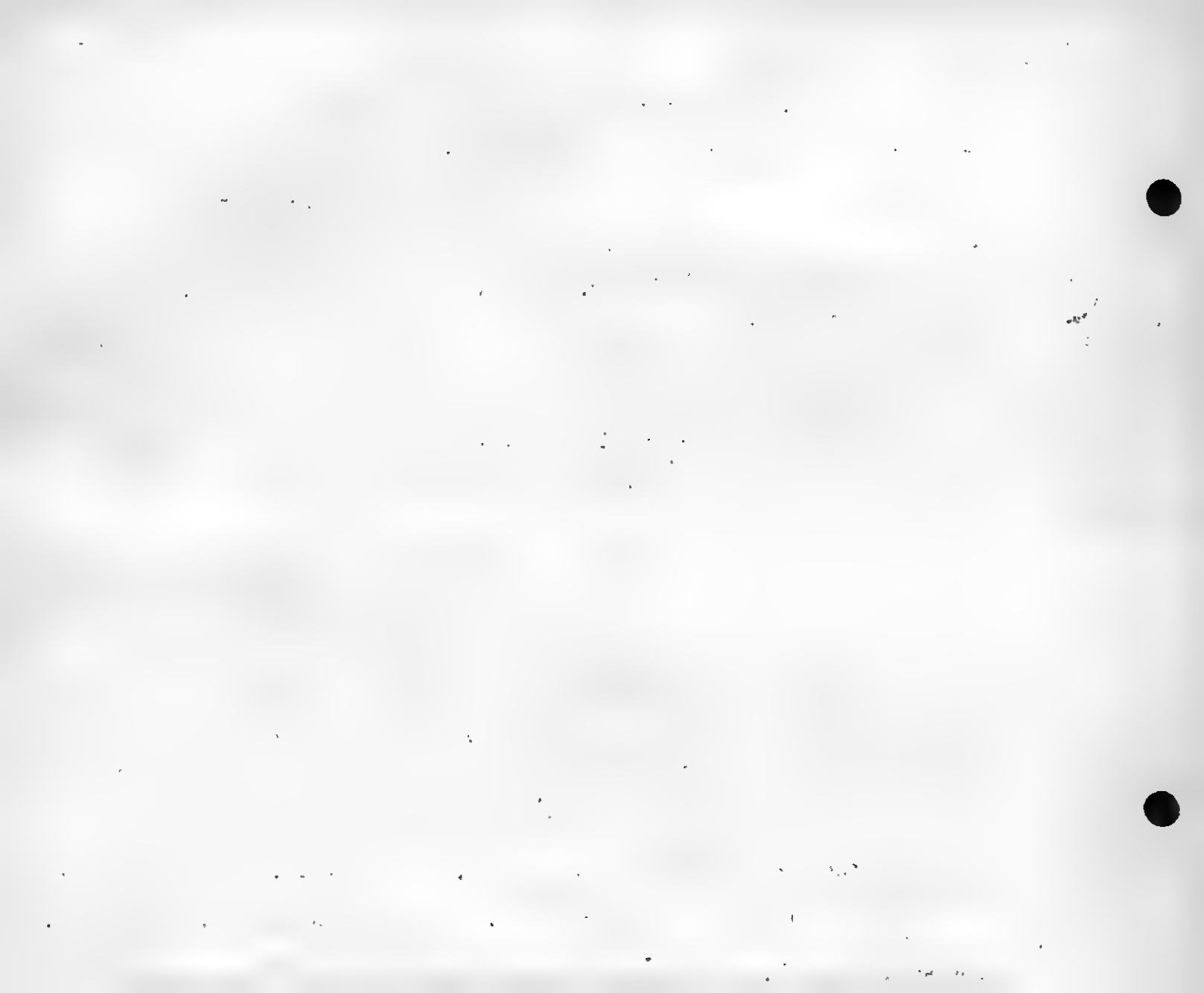
Information taken from birth cert. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02908

CERTIFICATE OF DEATH

02903

1. DECEASED NAME (Type or print) Baby Girl Weaver			2a. DATE OF DEATH Month 2 Day 7 Year 1969			2b. HOUR 7:45 A	
3 SEX Female		4. RACE White		5. DATE OF BIRTH 02/04/69		6. AGE (In years last birthday) YRS 3	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George's		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER 6223 85th Place		14. FATHER'S NAME First James Middle Alvin Last Minnick		15. MOTHER'S MAIDEN NAME First Mary Middle E. Last Gross			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity Extreme DUE TO, OR AS A CONSEQUENCE OF Atelectasis Neonatorum CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/4/69 , 19____, to 2/7/69 , 19____, that (I) (we) last saw the deceased alive on 2/7/69 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Patrick A. Reardon M.D.				22c. DATE SIGNED 2-7-69			
22d. PHYSICIAN'S NAME (Type) Patrick A. Reardon, M.D.				22e. ADDRESS 9430 Lanham-Severn Rd. Seabrook, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-14-69		23c. NAME OF CEMETERY OR CREMATORY Pr. George's Gen. Hospital		23d. LOCATION (City or Town) (County) (State) Cheverly, Pr. Georges, Md.	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Administrator				25a. REC'D BY REGISTRAR FEB 19 1969		25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
304 REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)		First ANGELA		Middle MARY		Last WEBB		2a. DATE OF DEATH FEB Month 4 Day 69 Year		2b. HOUR 11:30 AM		
3. SEX Female		4 RACE Caucasian		5. DATE OF BIRTH 31 Jan 69			6. AGE (In years last birthday) — YRS.		IF UNDER 1 YEAR MONTHS 4 DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md.						
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAFHOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NA			12b. KIND OF BUSINESS OR INDUSTRY NA				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD		13b. COUNTY N. BEACH		13c. CITY OR TOWN N. BEACH		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Greenwood Ave Box 379 2nd St				
14. FATHER'S NAME First GEORGE Middle WILLIAM Last WEBB		15. MOTHER'S MAIDEN NAME First ANNIE Middle THOMSON Last THOMSON										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO NA		17. INFORMANT MOTHER SAME AS ITEM # 13		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> <u>7762</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Respiratory Distress Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>31 Jan</u> , 19 <u>69</u> , to <u>4 Feb</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4 Feb</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Martin Howowitz</u>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4 Feb 69</u>						
22d. PHYSICIAN'S NAME MARTIN HOWOWITZ, CAPT USAF MC		22e. ADDRESS MALCOLM GROW USAFHOSP ANDREWS AFB										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3/7/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PUBLIC CEMETERY</u>		23d. LOCATION (City or town) <u>Washington, D.C.</u>		(County) <u>Washington</u>		(State) <u>D.C.</u>		
24. FUNERAL DIRECTOR <u>Carl F. Cupula</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>FEB 21 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>						

VR A15
FROM REV

1. DECEASED NAME (Type or print) Bernard William Wesley		First Middle Last		2a. DATE OF DEATH 2/12/69 Month Day Year		2b. HOUR A.M. 5:50 P.	
3. SEX Male		4 RACE White		5 DATE OF BIRTH 10/03/83		6 AGE (In years last birthday) 85 YRS.	
7a BIRTHPLACE (State or foreign country) WASH D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md	
10 CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Prince George's		12a US-A. OCCUPAT.ON (Kind of work done during most of working life, even if retired) Blacksmith		12b KIND OF BUSINESS OR INDUSTRY BLACKSMITH HORSES	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Prince Geo.		13c INS OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 54-A Crescent Road	
14 FATHER'S NAME First Middle Last JOHN W. WESLEY		15 MOTHER'S MAIDEN NAME First Middle Last JULIA M. CORN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO. 213-22-2231		17 INFORMANT HOWARD D. WESLEY SEABROOK MD		Address 9508 FRANKLIN AVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days 2 weeks 1 year	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pneumonia - 1 month ago							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home farm, street factory office building, etc.)		21f LOCATION Street or R.F.D. No. City or town County State			
22a I certify that (I) (this hospital) attended the deceased from December, 1968, to Feb. 11, 1969, that (I) (we) last saw the deceased alive on Feb. 11, 1969, and that in (my) (our) opinion death occurred on the date and hour noted from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b SIGNATURE Thos Woodard				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 2-12-1969	
22d PHYSICIAN'S NAME (Type)		22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 2-15-69		23c NAME OF CEMETERY OR CREMATORY St Marys Cem		23d LOCATION (City or Town) (County) (State) Laurel Pg Md	
24 FUNERAL DIRECTOR D. J. ...		ADDRESS		25 REC'D BY REGISTRAR DATE FEB 19 1969		25b REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ARDEN CHILE WEYGANDT			2a. DATE OF DEATH Month 2 Day 27 Year 69			2b. HOUR 8:55 M.	
3. SEX M		4. RACE W		5. DATE OF BIRTH 5-27-1891		6. AGE (In years last birthday) 77 YRS.	
7a. BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md.	
10. CITY OR TOWN OF DEATH GREENBELT, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREENBELT CONV. CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FOREMAN CONSTRUCTION		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN BELTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 10409 43RD AVENUE		14. FATHER'S NAME First George G. Middle Weygandt Last Weygandt		15. MOTHER'S MAIDEN NAME First Sarah Middle Sollenburger Last Sollenburger		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. 377-28-2339		17. INFORMANT W. Earl Weygandt - Ave., College Pk., Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Terminal Bronchopneumonia							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If injury, notify medical examiner)		21b. TIME OF INJURY Hour A.M. 19 Month 7 Day 27 Year 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) —		21f. LOCATION Street or R.F.D. No. — City or Town — County — State —		22a. I certify that (I) (this hospital) attended the deceased from July 2, 1965 , to Feb 27, 1969 , that (I) (we) last saw the deceased alive on Feb 27, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE Thomas S. Sappington MD		22c. DATE SIGNED 2/27/69		22d. PHYSICIAN'S NAME (Type) THOMAS S. SAPPINGTON		22e. ADDRESS 2233 WISCONSIN AVE. NW. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/3/69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR MAR 5 1969		25b. REGISTRAR'S SIGNATURE —	



02912

CERTIFICATE OF DEATH

02901

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR	
James		H.	White		2- Month 26 Day 69 Year		M	
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male	White		5-16-91		77 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Wash., D.C.		USA				Prince George Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Riverdale		Eugene Leland Memorial		CABINET MAKER		FURNITURE		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d US DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		Prince George		Riverdale				5610 54th. Ave.,
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle
JOHN S.		WHITE			UNKNOWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
NO		57910 3733		Thelma White (Spouse) and Medical Records		SAME AS #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE								ONE MONTH
4124 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) ARTERIOSCLEROTIC CARDIOVASCULAR DIS.								UNKNOWN
DUE TO, OR AS A CONSEQUENCE OF								
lost.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
		HOUR A.M. Month Day Year P.M. 19						
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or RFD No				
22a I certify that (I) (this hospital) attended the deceased from March 1, 1969, to Feb 26, 1969, that (I) (we) lost the deceased alive on Feb 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		C. J. Houmann		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED
								2-26-69
22d PHYSICIAN'S NAME (Type)		C. J. Houmann, M.D.		22e ADDRESS		440 Queensbury Rd., Riverdale, Md.		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
BURIAL		3-1-1969		FORT LINCOLN CEM		COLMAR MANOR, MARYLAND		
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
W.W. CHAMBERS CO. RIVERDALE, MD				MAR 6 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1
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02913

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02908

Information taken from birth certificate
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR A	
Baby/Boy/John Thomas White, Jr.						Feb. 7, 1969			1:15M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male		White		Feb. 5, 1969		YRS.		MONTHS		DAYS
								2		HOURS
										MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Prince George's Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Geo. General							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland			Prince Georges			New Carrollton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6103 Lamont Drive
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
John Thomas White			Doris Marie Robey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>atelectasis of lung</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u>prematurity</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)				
			HOUR A.M. Month Day Year P.M.							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> , 19 <u>69</u> , to <u>2/7</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>2/7</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>Andrew G. Aronfy M.D.</u>										<u>2-7-69</u>
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
Andrew G. Aronfy, M.D.						6803 Good Luck Rd., New Carrollton, Md.				
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>			<u>2/8/1969</u>		<u>Wash National</u>		<u>Suitland, Prince Georges</u>			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR 1969							
<u>Matthewly 131-11th St. S.E.</u>			FEB 10 1969							



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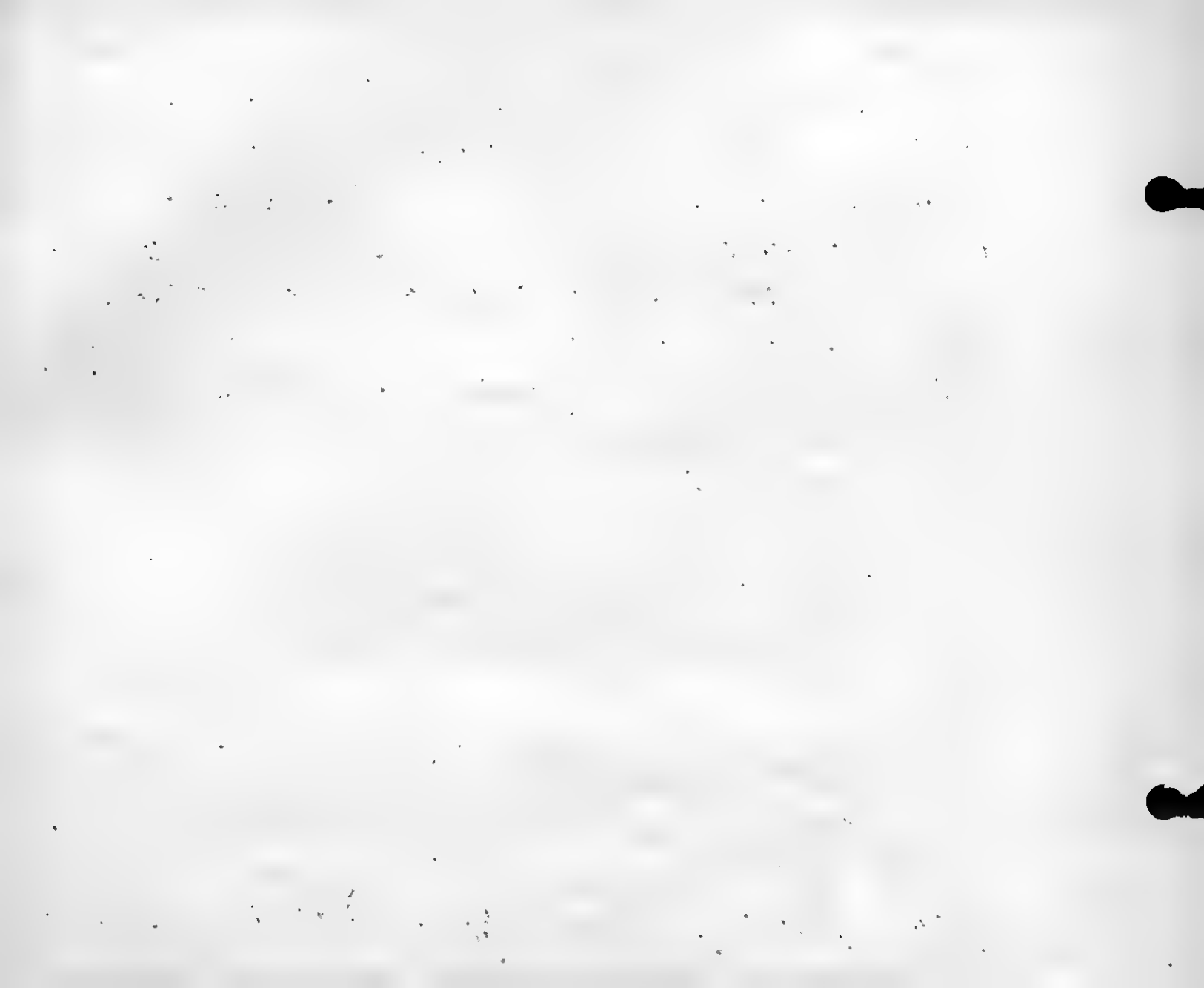
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02917

CERTIFICATE OF DEATH

02909

1. DECEASED NAME (Type or print) DENNIS			First Middle Last			2a. DATE OF DEATH Month Day Year 2 27 69			2b. HOUR 9.30P. M		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 7/14/10			6. AGE (In years last birthday) 58 YRS.		
7a. BIRTHPLACE (State or foreign country) W. VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH PRINCE GEORGE Md		
10. CITY OR TOWN OF DEATH HYATTSVILLE, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5009 40TH PL.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ENGINEER			12b. KIND OF BUSINESS OR INDUSTRY BUILDING		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.			13b. COUNTY PR. GEORGE CO.			13c. CITY OR TOWN HYATTSVILLE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 5009-40TH PLACE			14. FATHER'S NAME First Middle Last JESSIE R. WILKINSON			15. MOTHER'S MAIDEN NAME First Middle Last SUSAN M. SHINN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO			17. INFORMANT DENNIS L. WILKINSON			Address 3413 TOLEDO TERRACE HYATTSVILLE MD.		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism 3760 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atrial fibrillation DUE TO OR AS A CONSEQUENCE OF (c) Phosho heart disease DUE TO OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Thyroid carcinoma, ASCVD, AI, T.I. & I.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from Jan 27, 1968 , to 28 Feb, 1969 , that (1) (we) last saw the deceased alive on 26 Feb 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert Deitz						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2-28-69		
22d. PHYSICIAN'S NAME (Type) Robert Deitz						22e. ADDRESS Prince Georges Pkwy Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 3/14/69			23c. NAME OF CEMETERY OR CREMATORY MASONIC CEMETERY			23d. LOCATION (City or Town) (County) (State) SHINNSTON HARRISON, W. VA.		
24. FUNERAL DIRECTOR W. W. CHAMBERS CO.						ADDRESS RIVERDALE MD.			25a. REC'D BY REGISTRAR HARMER FUNERAL HOME SHINNSTON W. VA.		
25b. REGISTRAR'S SIGNATURE Charles Judge						DATE MAR 6 1969					



CERTIFICATE OF DEATH

02915

02910

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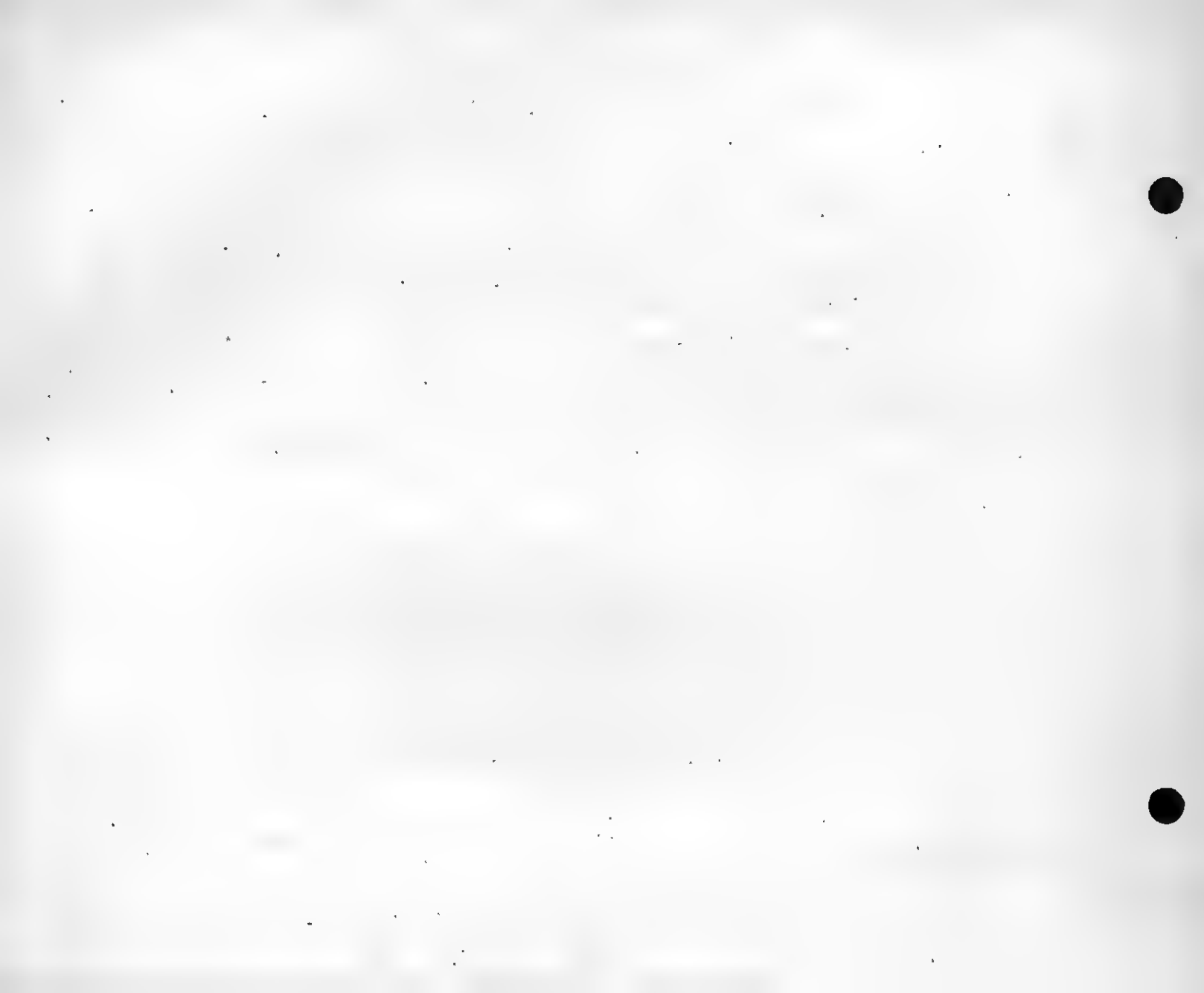
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Temple Hills, 20031</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Temple Hills, 20031</u>	
c. LENGTH OF STAY IN TB <u>4 years</u>		d. STREET ADDRESS <u>4305-WELDON DR. 20031</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RAYMOND CHARLES WINCHESTER</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>11</u> Year <u>1969</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1891</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	
11. IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUDITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gen. Acc. Office</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WINCHESTER</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-26-8630</u>	
17. INFORMANT <u>Sarah Winchester</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>104</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>less than 1 hr.</u>		20. YEARS <u>—</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21. I certify that (I) (this hospital) attended the deceased from <u>July 1969</u> to <u>Feb. 11, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb. 9, 1969</u> , and that death occurred at <u>3:45 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Max E. Feldman M.D.</u>		22b. DATE SIGNED <u>2/11/69</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAX E. FELDMAN M.D.</u>		22d. ADDRESS <u>5721-Temple Hills Rd. Temple Hills, Md. 20031</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/14/69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Wilhelm</u>		25a. REC'D BY REGISTRAR <u>FEB 17 1969</u>	
25b. REGISTRAR'S SIGNATURE <u>—</u>		25c. ADDRESS <u>4308 Suitland Rd., S. E., Suitland, Md., 20023</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Audie MAY Wood						FEB 27 1969			9:40 P
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
F	W		8-18-81			87 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Kentucky		U.S.				PRINCE GEORGES Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Forestville			REGENT Nsg. Home			HOUSE WIFE		HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
DC			DC		Wash DC	YES	2003 W. DAVIS ST. S.E.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
ANDREW PINKSTON						MARY VORRHIES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
NO			NO			ALPHA KRONK 2003 F. DAVIS ST. WASHINGTON DC			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure.</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) <u>Arteriosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5 Jan</u> , 19 <u>69</u> , to <u>27 Feb</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>26 Feb</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. H. Thibadeau MD</u> -DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>27 Feb 69</u>		
22d. PHYSICIAN'S NAME (Type) <u>J. H. THIBADEAU</u>					22e. ADDRESS <u>3112 Alameda St NE -DC 20020</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
BURIAL		3-3-69		HILLCREST MEN. PARK		LEXINGTON			KY
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm</u> 4308 SUTLAND RD SUTLAND MD					25a. REC'D BY REGISTRAR DATE <u>MAR 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

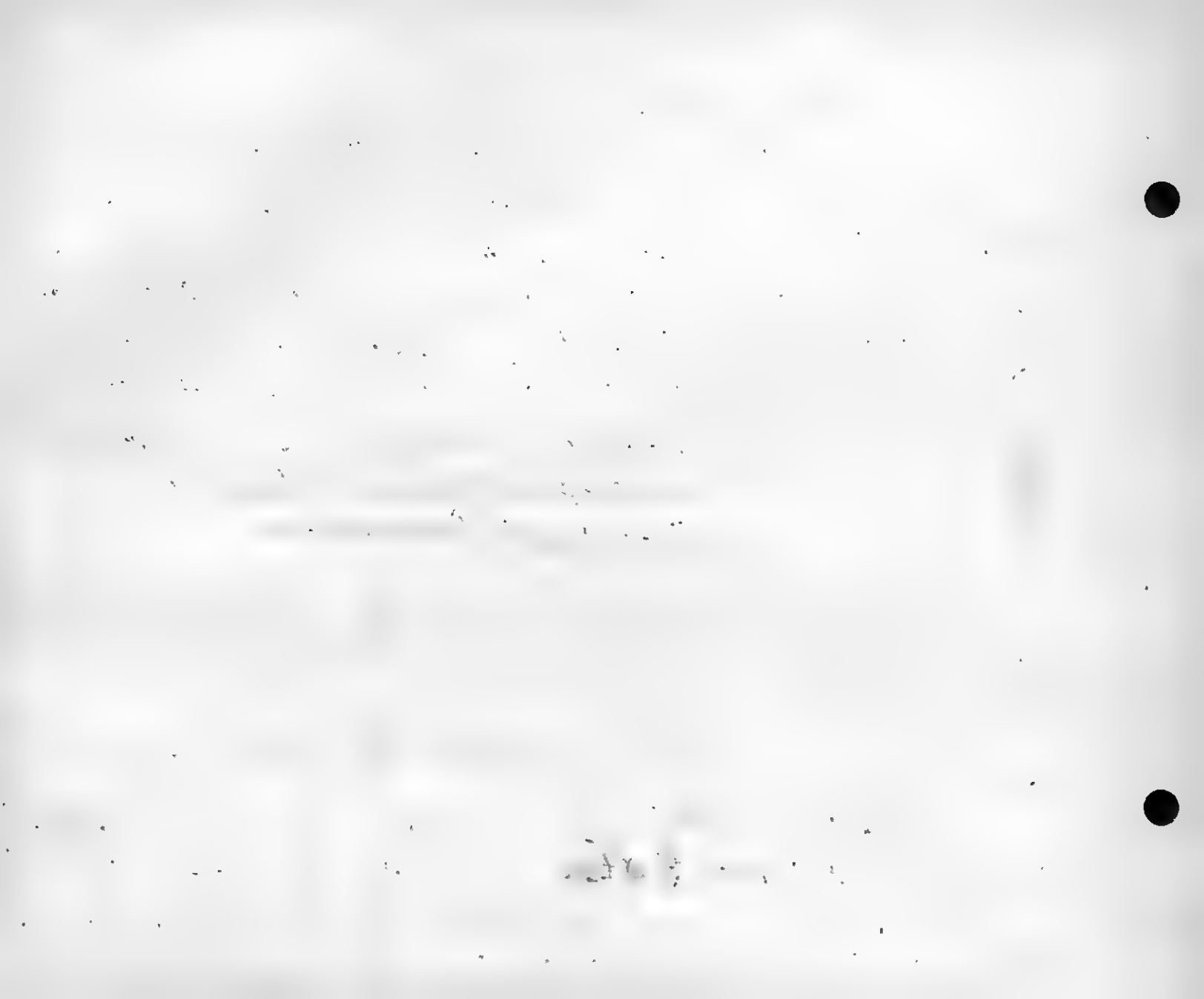


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Dr. Kohnen called - 0 ket my signing

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
Carrie Lease Wood						Month Day Year		11:00 P M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
F		white		1-26-1886		83 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna		U.S.A.				Prince Georges Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Glenn Dale			Box 185 Daisy Lane			Housewife			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c. INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.			Prince Georges			YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 185 Daisy Lane	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Edward Prowell			Emma Jane Lease						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO			17. INFORMANT Address			
No			212-12-6841-D			Heraldine Deibel same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>									Minutes
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intermedicent heart disease</u>									Year
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Atherosclerosis</u>									Year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f LOCATION		Street or R.F.D. No.		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>66</u> , to <u>2/27</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1/25/1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE			DEGREE		ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
H. James Rutz MD					X				2/27/69
22d. PHYSICIAN'S NAME (Type)			22e ADDRESS						
H. James Rutz			RD #1 Glenn Dale Md						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		March 3, 1969		Ft Lincoln Cemetery		Colmar Manor, Pro Geo Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons Hyattsville, Md.					DATE MAR 4 1969		Charles Judge		



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Thomas B. Wright</i>						2a. DATE OF DEATH <i>Feb 5 1969</i>			2b. HOUR <i>12:25 PM</i>		
3 SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>June 22, 77</i>		6 AGE (In years last birthday) <i>91</i>		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Hamersoy, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Prince George Md</i>					
10 CITY OR TOWN OF DEATH <i>Clinton Md</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pine View Garden</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov.</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Charles</i>		13c. CITY OR TOWN <i>Marbury</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>---</i>			
14 FATHER'S NAME <i>Saber</i>				15. MOTHER'S MAIDEN NAME <i>Wright</i>				15. MOTHER'S MAIDEN NAME First <i>Mary Allen</i>			
16a. WAS DECEASED EVER IN U.S. ARMED SERVICES? (If yes give dates of service) <i>Yes, PO, or unknown</i>		16b. SOCIAL SECURITY NO <i>578-20-9304</i>		17 INFORMANT <i>T. Wilber Wright, Marbury, Md.</i>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Circulatory Collapse</i>										<i>10 min</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Uremia, Terminal</i>										<i>2 weeks</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerotic Cardiovascular disease</i>										<i>2-3 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Alfred R. Lapin</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2/5/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPIN, MD</i>		22e. ADDRESS <i>CLINTON, MD</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Feb. 7, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Marbury Baptist</i>		23d. LOCATION (City or Town) (County) (State) <i>Marbury, Charles, Md.</i>					
24. FUNERAL DIRECTOR <i>Arehart Funeral Home Inc., La Plata, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>FEB 10 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William R. Under</i>					

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) PAMELA			First Middle Last R. YOUNG			2a. DATE OF DEATH Month Day Year 2-13-1969		2b. HOUR 4:30 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 29, 1883		6. AGE (In years lost birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Nebraska		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Fla.		13b. COUNTY Unknown		13c. CITY OR TOWN Lakeland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1033 Success Ave.	
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Dean Young 1702 Langley Way, Langley Pk., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) A S H D APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma Colon. Cerebral arteriosclerosis									
19a. DATE OF OPERATION Nov '68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of colon			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year 2-13-69 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 15, 1969 , to Jan 13, 1969 , that (I) (we) last saw the deceased alive on Jan 12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard F. Shaw M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-14-69			
22d. PHYSICIAN'S NAME (Type) DR RICHARD F. SHAW		22e. ADDRESS 1324-Mich. Ave NE							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 17, 1969		23c. NAME OF CEMETERY OR CREMATORY "Old Cemetery"			23d. LOCATION (City or Town) (County) (State) Ada, Ohio		
24. FUNERAL DIRECTOR ADDRESS Joseph Gawler's Sons, Inc. Washington, D.C.				25a. REC'D BY REGISTRAR DATE FEB 19 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

1/6/20

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>02920</div> <div>CERTIFICATE OF DEATH</div> <div>02915</div>											
1. DECEASED-NAME (Type or print) First Middle Last Evrripidis D. Zervas						2a. DATE OF DEATH Month Day Year 2/13/69			2b. HOUR A M 3:30		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 05/09/00		6. AGE (In years lost birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Greece		7b. CITIZEN OF WHAT COUNTRY? Greece		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's County Md.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Prince George's		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) clerk		12b. KIND OF BUSINESS OR INDUSTRY whls. liquo					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Geo		13c. CITY OR TOWN Colmar Manor		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4320 Lawrence Street			
14. FATHER'S NAME First Middle Last Dimitri Zervas				15. MOTHER'S MAIDEN NAME First Middle Last Harikleia (unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) No		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Dimitri E. Zervas 13 a, b, c, d, e above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Pending Examination of Brain/											
DUE TO, OR AS A CONSEQUENCE OF Parkinson's syndrome											
(b) / Brain going to National Institute of Health/											
DUE TO, OR AS A CONSEQUENCE OF Death in Maryland/											
(c) Cerebral arteriosclerosis											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture lt. femur (fell at home)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 2 4 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell at home 10 days before coming to hospital							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State P.G. Md.							
22a. I certify that (I) (this hospital) attended the deceased from 02/11/69 , 19__, to 2/13/69 , 19__, that (I) (we) last saw the deceased alive on 2/12/69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Natural and Accident											
22b. SIGNATURE Bijan Chovanlou, M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/14/69			
22d. PHYSICIAN'S NAME (Type) B. Chovanlou						22e. ADDRESS Prince George's Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 17 Feb. 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Md.					
24. FUNERAL DIRECTOR Rinaldi Funeral Home, Inc						7400 Georgia Ave. NW, DC 20012		25a. REGISTRY REGISTRATION DATE		25b. REGISTRAR'S SIGNATURE	

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